Imjudo

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the patient's diagnosis?

❒ Esophageal, Esophagogastric Junction and Gastric Cancer, *Continue to 2*

❒ Hepatocellular carcinoma, *Continue to 7*

❒ Non-small cell lung cancer (NSCLC), *Continue to 11*

❒ Other, please specify. _____, *No further questions*

2. Has the patient previously received a dose with the requested medication?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 4*

4. Will the requested medication be used as neoadjuvant treatment?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested medication be used in combination with durvalumab (Imfinzi)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the patient medically fit for surgery?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Has the patient previously received a dose with the requested medication?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to 9*

❒ Metastatic disease, *Continue to 9*

❒ Other, please specify. _____, *Continue to 9*

9. Is the patient eligible for transplant?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Will the requested medication be used in combination with durvalumab (Imfinzi)?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *Continue to 12*

❒ Metastatic disease, *Continue to 12*

❒ Recurrent disease, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

12. Will the requested medication be used in combination with durvalumab (Imfinzi) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the tumor negative for epidermal growth factor receptor EGFR exon 19 deletion and L858R mutations and anaplastic lymphoma kinase (ALK) rearrangements? ***ACTION REQUIRED***: If Yes, please attach chart notes or lab results of the absence of EGFR exon 19 deletion and L858R and ALK rearrangement.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*

❒ No, *Continue to 15*

❒ Unknown, *Continue to 14*

14. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. How many doses of therapy has the patient received with the requested medication?

_____doses, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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