Jemperli

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*

What is the ICD-10 code? _____

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

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is the patient less than 14 years of age?
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to C*

C. Is the patient receiving provider-administered combination oncology therapy or other provider-administered drug therapies at the same visit? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to H*

H. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to J*

J. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. What is the diagnosis?

❒ Ampullary adenocarcinoma, *Continue to 2*

❒ Breast Cancer, *Continue to 2*

❒ Colorectal Cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, *Continue to 2*

❒ Endometrial Carcinoma, *Continue to 2*

❒ Esophageal cancer, Esophagogastric Junction cancer and Gastric adenocarcinoma, *Continue to 2*

❒ Occult Primary Cancer, *Continue to 2*

❒ Ovarian cancer, *Continue to 2*

❒ Pancreatic adenocarcinoma, *Continue to 2*

❒ Small Bowel Adenocarcinoma, *Continue to 2*

❒ Solid Tumors, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo, Keytruda)?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to 4*

❒ No, *Continue to 8*

4. Is the requested drug being prescribed for the treatment of endometrial carcinoma when used as combination therapy?

❒ Yes, *Continue to 5*

❒ No, *Continue to 7*

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. How many months of treatment has the patient received with the requested drug?

_____months, *No further questions*

7. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

8. What is the diagnosis?

❒ Ampullary adenocarcinoma, *Continue to 48*

❒ Breast Cancer, *Continue to 19*

❒ Colorectal Cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, *Continue to 24*

❒ Endometrial Carcinoma, *Continue to 9*

❒ Esophageal cancer, Esophagogastric Junction cancer and Gastric adenocarcinoma, *Continue to 26*

❒ Occult Primary Cancer, *Continue to 37*

❒ Ovarian cancer, *Continue to 41*

❒ Pancreatic adenocarcinoma, *Continue to 54*

❒ Small Bowel Adenocarcinoma, *Continue to 45*

❒ Solid Tumors, *Continue to 14*

9. What is the requested regimen?

❒ Single agent, *Continue to 11*
❒ In combination with carboplatin and paclitaxel (for up to 6 doses of combination therapy followed by Jemperli monotherapy), *Continue to 10*

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

10. In which clinical setting will the requested drug be used?

❒ Recurrent disease, *No further questions*

❒ Stage III-IV disease, *No further questions*

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

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 12*

12. In which clinical setting will the requested drug be used?

❒ Advanced disease, *Continue to 13*

❒ Recurrent disease, *Continue to 13*

❒ Other, please specify. _____, *Continue to 13*

13. Has the disease progressed on or following prior treatment with a platinum-containing regimen (e.g., cisplatin, carboplatin)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. In which clinical setting will the requested drug be used?

❒ Recurrent disease, *Continue to 15*

❒ Advanced disease, *Continue to 15*

❒ Other, please specify. _____, *Continue to 15*

15. Is the tumor mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 16*

❒ No, *Continue to 16*

❒ Unknown, *Continue to 16*

16. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has the patient experienced disease progression on or following prior treatment?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Are there other satisfactory alternative treatment options available for the patient?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. What is the clinical setting in which the requested drug will be used?

❒ The patient had no response to preoperative systemic therapy, *Continue to 20*

❒ Recurrent unresectable disease, *Continue to 20*

❒ Stage IV disease, *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ No, *Continue to 21*

❒ Unknown, *Continue to 21*

21. Has the disease progressed on or following prior treatment?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Are there other satisfactory alternative treatment options available for the patient?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1)? ***ACTION REQUIRED***: If Yes, attach test results or chart note(s) confirming microsatellite instability-high (MSI-H), mismatch repair deficient or polymerase epsilon/delta (POLE/POLD1) tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ No, *Continue to 25*

❒ Unknown, *Continue to 25*

25. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

26. Will the requested drug be used as induction therapy for relieving dysphagia?
❒ Yes, *Continue to 27*
❒ No, *Continue to 30*

27. What is the patient's diagnosis?

❒ Esophageal cancer, *Continue to 28*

❒ Esophagogastric junction cancer, *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

28. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the patient a surgical candidate?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

30. Is the patient medically fit for surgery with surgically unresectable locoregional disease or does the patient have early stage disease?

❒ Yes, medically fit for surgery with surgically unresectable locoregional disease, *Continue to 31*

❒ Yes, the patient has early stage disease, *Continue to 31*

❒ No, *Continue to 33*

31. Will the requested drug be used for treatment of gastric adenocarcinoma?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

33. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. What is the clinical setting in which the requested drug will be used?

❒ Unresectable locally advanced disease, *Continue to 35*

❒ Recurrent disease, *Continue to 35*

❒ Metastatic disease, *Continue to 35*

❒ The patient is not a surgical candidate, *Continue to 35*

❒ Other, please specify. _____, *Continue to 35*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 36*

❒ No, *Continue to 36*

❒ Unknown, *Continue to 36*

36. Will the requested drug be used as palliative therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

37. Will the requested drug be used as a single agent?

❒ Yes, *Continue to 38*

❒ No, *Continue to 38*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 39*

❒ No, *Continue to 39*

❒ Unknown, *Continue to 39*

39. Has the disease progressed on or following prior treatment?

❒ Yes, *Continue to 40*

❒ No, *Continue to 40*

40. Are there other satisfactory alternative treatment options available for the patient?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

41. Which of the following applies to the patient's disease?

❒ Epithelial ovarian cancer, *Continue to 42*

❒ Fallopian tube cancer, *Continue to 42*

❒ Primary peritoneal cancer, *Continue to 42*

❒ Carcinosarcoma (malignant mixed Mullerian tumors), *Continue to 42*

❒ Clear cell carcinoma of the ovary, *Continue to 42*

❒ Mucinous carcinoma of the ovary, *Continue to 42*

❒ Grade 1 endometrioid carcinoma, *Continue to 42*

❒ Low-grade serous carcinoma/ovarian borderline epithelial tumors, *Continue to 42*

❒ Other, please specify. _____, *Continue to 42*

42. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 44*

❒ Persistent disease, *Continue to 44*

❒ Advanced disease, *Continue to 44*

❒ Other, please specify. _____, *Continue to 44*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

45. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 46*
❒ No, *Continue to 46*

46. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease, *Continue to 47*

❒ Metastatic disease, *Continue to 47*

❒ Other, please specify. _____, *Continue to 47*

47. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR) or polymerase epsilon/delta (POLE/POLD1)? ***ACTION REQUIRED***: If Yes, attach test results or chart note(s) confirming microsatellite instability-high, mismatch repair deficient, or polymerase epsilon/delta (POLE/POLD1) tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

48. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 50*

❒ Advanced disease, *Continue to 50*

❒ Other, please specify. _____, *Continue to 50*

50. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 51*

❒ Subsequent treatment, *Continue to 51*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 52*

❒ No, *Continue to 52*

❒ Unknown, *Continue to 52*

52. Has the disease progressed on or following prior treatment?

❒ Yes, *Continue to 53*

❒ No, *Continue to 53*

53. Are there other satisfactory alternative treatment options available for the patient?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

54. Will the requested drug be used as a single agent?

❒ Yes, *Continue to 55*

❒ No, *Continue to 55*

55. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 56*

❒ Locally advanced disease, *Continue to 56*

❒ Metastatic disease, *Continue to 56*

❒ Other, please specify. _____, *Continue to 56*

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

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 57*

❒ No, *Continue to 57*

❒ Unknown, *Continue to 57*

57. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (the patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of walking hours)?

❒ Yes, *No Further Questions*

❒ No, *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)**