# Loqtorzi

## 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**

 Loqtorzi SGM 6237-A, CFT SOC 7299-A – 2/2026.

**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**

**Site of Service Questions (SOS):**

1. Where will this drug be administered?
❒ On-campus outpatient hospital, *Continue to 2*
❒ Off-campus outpatient hospital, *Continue to 2*
❒ Pharmacy, *skip to Criteria Questions*
❒ Physician office, *skip to Criteria Questions*
❒ Home infusion, *skip to Criteria Questions*
❒ Ambulatory surgical, *skip to Criteria Questions*

2. Is the patient less than 14 years of age?
❒ Yes, *skip to Criteria Questions*
❒ No, *Continue to 3*

3. Will the member's treatment plan for the requested drug be completed within the next 3 months? ***Action Required***: If yes, please attach documentation of treatment plan end date.
❒ Yes, *skip to Criteria Questions*
❒ No, *Continue to 4*

4. 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 Criteria Questions*
❒ No, *Continue to 5*

5. 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 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 Criteria Questions*
❒ No, *Continue to 6*

6. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, 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 Criteria Questions*
❒ No, *Continue to 7*

7. 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 Criteria Questions*
❒ No, *Continue to 8*

8. 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 Criteria Questions*
❒ No, *Continue to 9*

9. 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 Criteria Questions*
❒ No, *Continue to 10*

10. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND does not have access to a caregiver? ***Action Required***: If yes, please attach supporting clinical documentation.
❒ Yes, *skip to Criteria Questions*
❒ No, *Continue to 11*

11. 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 clinical documentation.
❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

**Criteria Questions:**

1. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the patient's diagnosis?
❒ Anal carcinoma, *Continue to 14*
❒ Colon cancer, *Continue to 14*
❒ Appendiceal adeonocarcinoma, *Continue to 14*
❒ Rectal cancer, *Continue to 14*
❒ Nasopharyngeal carcinoma (NPC), *Continue to 3*
❒ Non-small cell lung cancer (NSCLC), *Continue to 8*
❒ Small bowel adenocarcinoma, *Continue to 14*
❒ Other, please specify. _____, *No further questions*

3. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 17*

4. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is there evidence of disease progression while on the current regimen?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Will the requested drug be used as first-line therapy?
❒ Yes, *Continue to 7*
❒ No, *No Further Questions*

7. How many months has the patient received therapy with the requested drug?
_____months, *No further questions*

8. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 9*
❒ No, *Continue to 17*

9. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is there evidence of disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Is this continuation request being used for neoadjuvant/adjuvant treatment of NSCLC?
❒ Yes, *Continue to 12*
❒ No, *Continue to 13*

12. How many cycles of treatment with the requested drug has the patient received?

_____cycles, *No further questions*

13. How many months has the patient received therapy with the requested drug?
_____months, *No further questions*

14. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 15*
❒ No, *Continue to 17*

15. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is there evidence of disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. What is the patient's diagnosis?
❒ Anal carcinoma, *Continue to 22*
❒ Colon cancer, *Continue to 29*
❒ Rectal cancer, *Continue to 29*
❒ Appendiceal adenocarcinoma, *Continue to 29*
❒ Nasopharyngeal carcinoma (NPC), *Continue to 18*
❒ Non-small cell lung cancer (NSCLC), *Continue to 32*
❒ Small bowel adenocarcinoma, *Continue to 26*

18. How will the requested drug be used?
❒ In combination with cisplatin and gemcitabine, *Continue to 19*
❒ As a single agent, *Continue to 20*
❒ Other, please specify. _____, *No further questions*

19. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease, *No further questions*
❒ Recurrent locally advanced disease, *No further questions*
❒ Unresectable disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

20. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *Continue to 21*
❒ Unresectable disease, *Continue to 21*
❒ Metastatic disease, *Continue to 21*
❒ Other, please specify. _____, *Continue to 21*

21. Has the patient experienced disease progression on or after platinum-based chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 23*
❒ Subsequent treatment, *Continue to 23*

23. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease, *Continue to 24*
❒ Other, please specify. _____, *Continue to 24*

24. Has the patient received prior immunotherapy?
❒ Yes, *Continue to 25*
❒ No, *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 a single agent?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. What is the clinical setting in which the requested drug will be used?
❒ Advanced disease, *Continue to 28*
❒ Locally unresectable disease, *Continue to 28*
❒ Medically inoperable disease, *Continue to 28*
❒ Metastatic disease, *Continue to 28*
❒ Other, please specify. _____, *Continue to 28*

28. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, or polymerase epsilon/delta mutation with ultra-hypermutated phenotype tumors status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

29. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. What is the clinical setting in which the requested drug will be used?
❒ Unresectable disease, *Continue to 31*
❒ Medically inoperable disease, *Continue to 31*
❒ Advanced disease, *Continue to 31*
❒ Metastatic disease, *Continue to 31*
❒ Other, please specify. _____, *Continue to 31*

31. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, or polymerase epsilon/delta mutation with ultra-hypermutated phenotype tumors status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

32. Will the requested drug be used in combination with platinum-doublet chemotherapy?

❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. What is the clinical setting in which the requested drug will be used?
❒ Treatment of advanced disease, *Continue to 34*
❒ Neoadjuvant treatment, *Continue to 36*
❒ Other, please specify. _____, *No further questions*

34. What is the place in therapy in which the requested drug will be used?
❒ First-line therapy, *Continue to 35*
❒ Subsequent therapy, *Continue to 35*

35. Will the requested drug be continued as single agent maintenance therapy?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

36. Will the requested drug be continued as single agent adjuvant therapy after surgery?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Is the tumor negative for EGFR mutations (e.g., exon 19 deletions or L858R) and ALK mutations? ***ACTION REQUIRED***: Please attach chart note(s) or test results of EGFR mutations and ALK rearrangements status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No ***ACTION REQUIRED****: Submit supporting documentation, Continue to 38*
❒ Unknown, *Continue to 38*

38. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ 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)**

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



**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**