Padcev

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 diagnosis?

❒ Urothelial carcinoma - Bladder cancer, *Continue to 2*

❒ Urothelial carcinoma - Primary carcinoma of the urethra, *Continue to 2*

❒ Urothelial carcinoma - Upper genitourinary tract tumors, *Continue to 2*

❒ Urothelial carcinoma - Urothelial carcinoma of the prostate, *Continue to 2*

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

2. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 4*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

❒ First line therapy, *Continue to 5*

❒ Subsequent therapy, *Continue to 10*

5. What is the requested regimen?

❒ In combination with pembrolizumab (Keytruda), *Continue to 6*

❒ Other, please specify. _____, *Continue to 6*

6. What is the diagnosis?

❒ Urothelial carcinoma - Bladder cancer, *Continue to 7*

❒ Urothelial carcinoma - Primary carcinoma of the urethra, *Continue to 9*

❒ Urothelial carcinoma - Upper genitourinary tract tumors, *Continue to 9*

❒ Urothelial carcinoma - Urothelial carcinoma of the prostate, *Continue to 9*

7. Will the drug be used for either of the following: a) Metastatic or local recurrence post-cystectomy or b) Muscle invasive local recurrence or persistent disease in a preserved bladder?

❒ Yes, *No Further Questions*

❒ No, *Continue to 8*

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

❒ Stage II disease, *No further questions*

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

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

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

10. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient ineligible for cisplatin-containing chemotherapy?
❒ Yes, *Continue to 14*
❒ No, *Continue to 12*

12. Has the patient received prior treatment with a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient received prior treatment with a programmed death receptor-1 (PD-1) (e.g., Keytruda, Opdivo) or programmed death-ligand (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the diagnosis?

❒ Urothelial carcinoma - Bladder cancer, *Continue to 15*

❒ Urothelial carcinoma - Primary carcinoma of the urethra, *Continue to 17*

❒ Urothelial carcinoma - Upper genitourinary tract tumors, *Continue to 18*

❒ Urothelial carcinoma - Urothelial carcinoma of the prostate, *Continue to 18*

15. Will the drug be used for either of the following: a) Metastatic or local recurrence post-cystectomy or b) Muscle invasive local recurrence or persistent disease in a preserved bladder?
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

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

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Stage II disease, *No further questions*

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

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

❒ Recurrent disease, *No further questions*

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

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

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *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