Pemetrexed Products

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

 Pemetrexed Products SGM 1900-A – 01/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Bladder cancer (transitional cell urothelium cancer), *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Mullerian tumor], clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumor [low malignant potential], or mucinous carcinoma of the ovary), *Continue to 2*

❒ Fallopian tube cancer, *Continue to 2*

❒ Non-small cell lung cancer (non-squamous histology), including leptomeningeal metastases, *Continue to 2*

❒ Pleural or Peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma, *Continue to 2*

❒ Primary central nervous system (CNS) lymphoma, *Continue to 2*

❒ Primary peritoneal cancer, *Continue to 2*

❒ Thymoma or thymic carcinoma, *Continue to 2*

❒ Vaginal cancer, *Continue to 2*

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

2. Is this a request for continuation of therapy with the requested medication?

❒ Yes, *Continue to 3*

❒ No, *Continue to 7*

3. Is this continuation request for the treatment of malignant pleural mesothelioma in combination with pembrolizumab [Keytruda]?

❒ Yes, *Continue to 4*

❒ No, *Continue to 6*

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

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. How many continuous months of treatment has the patient received with the requested medication?

_____ months, *No further questions*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. What is the diagnosis?

❒ Bladder cancer (transitional cell urothelium cancer), *Continue to 14*

❒ Cervical cancer, *Continue to 19*

❒ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Mullerian tumor], clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumor [low malignant potential], or mucinous carcinoma of the ovary), *Continue to 16*

❒ Fallopian tube cancer, *Continue to 16*

❒ Non-small cell lung cancer (non-squamous histology), including leptomeningeal metastases, *Continue to 8*

❒ Pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma, *Continue to 9*

❒ Primary central nervous system (CNS) lymphoma, *Continue to 18*

❒ Primary peritoneal cancer, *Continue to 16*

❒ Thymoma or thymic carcinoma, *Continue to 13*

❒ Vaginal cancer, *Continue to 20*

8. What is the histology for the disease?

❒ Non-squamous histology, *No further questions*

❒ Squamous histology, *No further questions*

9. What is the requested regimen?

❒ As a single agent, *No further questions*

❒ In combination with cisplatin or carboplatin, *No further questions*

❒ In combination with bevacizumab (Avastin) and either cisplatin or carboplatin, *No further questions*

❒ In combination with durvalumab (Imfinzi) and either cisplatin or carboplatin, *No further questions*

❒ In combination with pembrolizumab and platinum chemotherapy, *Continue to 10*

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

10. Is this request to treat malignant pleural mesothelioma?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. What is the place in therapy in which the requested medication be given?

❒ First-line treatment, *Continue to 12*

❒ Subsequent treatment, *Continue to 12*

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

❒ Unresectable advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

13. Will the requested medication be given as a single agent?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

❒ Locally advanced disease, *Continue to 15*

❒ Metastatic disease, *Continue to 15*

❒ Relapsed disease, *Continue to 15*

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

15. Will the requested medication be given as second-line treatment?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

❒ Persistent disease, *Continue to 17*

❒ Recurrent disease, *Continue to 17*

❒ Other, please specify. _____, *Continue to 17*

17. Will the requested medication be given as single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Will the requested medication be given as single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Metastatic disease, *No further questions*

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

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

20. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 21*

❒ Subsequent treatment, *Continue to 21*

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

❒ Recurrent disease, *Continue to 22*

❒ Metastatic disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

22. Will the requested medication be used as a single agent?
❒ 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