Phesgo

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 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Phesgo SGM 3986-A – 6/2024.

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

Criteria Questions:

1. What is the diagnosis?

❒ Breast cancer, *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 6*

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

4. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) treatment of breast cancer, *Continue to 5*

❒ Adjuvant treatment of breast cancer, *Continue to 5*

❒ Treatment of recurrent or metastatic breast cancer, *No further questions*

❒ The disease had no response to preoperative systemic therapy, *No further questions*

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

5. How many months has the patient received therapy with the requested medication?

_____months, *No further questions*

6. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 7*

❒ HER2 negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 7*

❒ Unknown, *Continue to 7*

7. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) treatment of breast cancer, *Continue to 8*

❒ Adjuvant treatment of breast cancer, *Continue to 9*

❒ Treatment of recurrent breast cancer, *No further questions*

❒ Treatment of metastatic breast cancer, *No further questions*

❒ The disease had no response to preoperative systemic therapy, *No further questions*

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

8. Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

9. Is the disease either node-positive or at high risk for recurrence?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

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10. Will the requested drug be used in combination with chemotherapy?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. How many months of therapy with the requested medication has the patient previously been treated with?
_____months, *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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