Rybrevant Faspro

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

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 Care Criteria Questions:

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

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

3. 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 4*

4. Is this request to continue previously established treatment with the requested medication? ***Action Required:*** Please attach supporting clinical documentation.
❒ Yes, *Continue to 5*
❒ No, *Skip to Clinical Criteria Questions*

5. 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 a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an administration? ***Action Required:*** If yes, please attach supporting clinical documentation.
❒ Yes, *Skip to Clinical Criteria Questions*
❒ No, *Continue to 6*

6. 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 7*

7. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the 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 8*

8. Are ***all*** alternative administration 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*

Clinical Criteria:

1. What is the diagnosis?
❒ Non-small cell lung cancer (NSCLC), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Is the request for continuation of therapy for epidermal growth factor receptor (EGFR)-positive NSCLC?
❒ Yes, *Continue to 3*
❒ No, *Continue to 7*

3. Is the requested drug being used in combination with lazertinib (Lazcluze)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Is there evidence of unacceptable toxicity on the current regimen?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

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

7. Which of the following applies to the patient's disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results confirming the presence of EGFR exon 20 insertion mutation, EGFR exon 19 deletion or exon 21 L858R mutation, where applicable. ***ACTION REQUIRED***: Submit supporting documentation.
❒ The disease has an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R mutation, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ The disease has an epidermal growth factor receptor (EGFR) exon 20 insertion mutation, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*
❒ None of the above, *No further questions*
❒ Unknown, *No further questions*

8. What is the clinical setting in which the requested drug will be used?
❒ Advanced disease, *Continue to 9*
❒ Recurrent disease, *Continue to 9*
❒ Metastatic disease, *Continue to 9*
❒ Other, please specify. _____, *Continue to 9*

9. What is the requested regimen?
❒ As a single agent, *Continue to 10*
❒ In combination with carboplatin and pemetrexed, *Continue to 11*
❒ Other, please specify. _____, *No further questions*

10. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *No further questions*
❒ Subsequent treatment, *No further questions*

11. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 12*
❒ Subsequent treatment, *Continue to 12*

12. What is the histology for the disease?
❒ Nonsquamous histology, *No further questions*
❒ Squamous histology, *No further questions*

13. What is the clinical setting in which the requested drug will be used?
❒ Advanced disease, *Continue to 15*
❒ Recurrent disease, *Continue to 15*
❒ Metastatic disease, *Continue to 15*
❒ Treatment of brain metastases from NSCLC, *Continue to 14*
❒ Other, please specify. _____, *No further questions*

14. What is the requested regimen?
❒ In combination with lazertinib (Lazcluze), *No further questions*
❒ In combination with carboplatin and pemetrexed, *No further questions*
❒ Other, please specify. _____, *No further questions*

15. Is the disease histology nonsquamous?
❒ Yes, *Continue to 17*
❒ No, *Continue to 16*

16. Will the requested drug be used in combination with lazertinib (Lazcluze)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 18*
❒ Subsequent treatment, *Continue to 18*

18. What is the requested regimen?
❒ In combination with carboplatin and pemetrexed, *Continue to 19*
❒ In combination with lazertinib, *Continue to 20*
❒ Other, please specify. _____, *No further questions*

19. Has the disease progressed on osimertinib (Tagrisso) or lazertinib (Lazcluze)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Has the disease progressed on osimertinib (Tagrisso), pemetrexed, or platinum based chemotherapy?
❒ 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