Rybrevant

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

 Rybrevant SGM 4745-A – 11/2024.

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

Clinical Criteria Questions:

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?
❒ Yes, *Continue to 3*
❒ No, *Continue to 6*

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 or disease progression on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Will the requested drug be used in combination with lazertinib (Lazcluze)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 10*

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

❒ First-line treatment, *Continue to 8*

❒ Subsequent treatment, *Continue to 8*

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

❒ Recurrent disease, *Continue to 9*

❒ Advanced disease, *Continue to 9*

❒ Metastatic disease, *Continue to 9*

❒ Other, please specify. _____, *Continue to 9*

9. Does the patient have an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming the presence of EGFR exon 19 deletion or exon 21 L858R substitution mutations.

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

10. 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 mutations or EGFR exon 19 deletion or exon 21 L858R or EGFR S768I, L861Q, and/or G719X mutations, where applicable.
❒ The disease with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*

❒ The disease with epidermal growth factor receptor (EGFR) S768I, L861Q, and/or G719X mutations, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ The disease with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*

❒ None of the above, *No further questions*

❒ Unknown, *No further questions*

11. What is the requested regimen?

❒ As a single agent, *Continue to 12*

❒ In combination with carboplatin and pemetrexed, *Continue to 14*

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

12. Has the disease progressed on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

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

❒ First-line therapy, *Continue to 16*

❒ Subsequent treatment, *Continue to 16*

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

❒ First-line treatment, *Continue to 15*

❒ Subsequent treatment, *Continue to 15*

15. What is the histology for the disease?

❒ Non-squamous histology, *Continue to 16*

❒ Squamous histology, *Continue to 16*

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

❒ Recurrent disease, *No further questions*

❒ Advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

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

17. Has the disease progressed on Tagrisso (osimertinib)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

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

❒ First-line treatment, *Continue to 19*

❒ Subsequent treatment, *Continue to 19*

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

❒ Advanced disease, *Continue to 20*

❒ Recurrent disease, *Continue to 20*

❒ Metastatic disease, *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

20. What is the histology for the disease?

❒ Non-squamous histology, *Continue to 21*

❒ Squamous histology, *Continue to 21*

21. Will the requested drug be used in combination with carboplatin and pemetrexed?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Locally advanced disease, *Continue to 26*

❒ Advanced disease, *Continue to 23*

❒ Recurrent disease, *Continue to 23*

❒ Metastatic disease, *Continue to 26*

❒ Other, please specify. _____, *Continue to 27*

23. Has the disease progressed on Tagrisso (osimertinib)?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

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

❒ First-line treatment, *Continue to 25*

❒ Subsequent treatment, *Continue to 25*

25. What is the histology for the disease?

❒ Non-squamous histology, *Continue to 27*

❒ Squamous histology, *Continue to 27*

26. Has the patient had disease progression on or after treatment with an EGFR tyrosine kinase inhibitor?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Will the requested drug be used in combination with carboplatin and pemetrexed?
❒ 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