Tevimbra

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

 CareFirst Tevimbra SGM 6422-A SOC 5374-A – 07/2025.

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 Service Questions (SOS):

A. Where will this drug be administered?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is the patient less than 14 years of age?
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to C*

C. 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 D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. 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 slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. 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 H*

H. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

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

J. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo, Keytruda)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Anal carcinoma, *Continue to 3*
❒ Esophageal and esophagogastric junction cancer, *Continue to 3*
❒ Gastric cancer, *Continue to 3*
❒ Head and neck cancer, *Continue to 3*
❒ Hepatocellular carcinoma, *Continue to 3*
❒ Histologic (Richter) transformation to diffuse large B-cell lymphoma, *Continue to 3*
❒ Small bowel adenocarcinoma, *Continue to 3*
❒ Colon cancer, *Continue to 3*
❒ Appendiceal cancer, *Continue to 3*
❒ Rectal cancer, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

3. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

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

5. What is the diagnosis?
❒ Anal carcinoma, *Continue to 6*
❒ Esophageal and esophagogastric junction cancer, *Continue to 9*
❒ Gastric cancer, *Continue to 26*
❒ Head and neck cancer, *Continue to 33*
❒ Hepatocellular carcinoma, *Continue to 22*
❒ Histologic (Richter) transformation to diffuse large B-cell lymphoma, *Continue to 25*
❒ Small bowel adenocarcinoma, *Continue to 37*
❒ Colon cancer, *Continue to 40*
❒ Appendiceal cancer, *Continue to 44*
❒ Rectal cancer, *Continue to 48*

6. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *Continue to 8*
❒ Subsequent treatment, *Continue to 8*

8. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

9. Will the requested medication be used for induction therapy for relieving dysphagia?
❒ Yes, *Continue to 10*
❒ No, *Continue to 13*

10. Will the requested medication be used in combination with platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the tumor express programmed death ligand 1 (PD-L1) (greater than or equal to 1)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming PD-L1 tumor status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*
❒ No, *Continue to 12*
❒ Unknown, *Continue to 12*

12. Is the patient planned to have esophagectomy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to 15*
❒ Recurrent disease, *Continue to 15*
❒ Metastatic disease, *Continue to 15*
❒ Other, please specify. _____, *Continue to 14*

14. Is the patient a surgical candidate?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. What is the place in therapy in which the requested medication will be used?
❒ First-line therapy, *Continue to 16*
❒ Subsequent therapy, *Continue to 20*

16. What is the histology?
❒ Squamous cell carcinoma, *Continue to 17*
❒ Adenocarcinoma, *Continue to 18*
❒ Other, please specify. _____, *No further questions*

17. Does the tumor express programmed death ligand 1 (PD-L1) (greater than or equal to 1)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming PD-L1 tumor status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ No, *Continue to 19*
❒ Unknown, *Continue to 19*

18. Does the patient have human epidermal growth factor receptor 2 (HER2) negative disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming HER2-negative disease.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ No, *Continue to 19*
❒ Unknown, *Continue to 19*

19. Will the requested medication be used in combination with platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Will the requested medication be used to treat esophageal squamous cell carcinoma?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the place in therapy in which the requested medication will be used?
❒ First line treatment, *Continue to 24*
❒ Subsequent treatment, *Continue to 24*

24. Is the patient deemed ineligible for resection, transplant, or locoregional therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Will the requested medication be used in combination with zanubrutinib (Brukinsa)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

26. Will the requested medication be used to treat gastric adenocarcinoma?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Will the requested medication be used in combination with platinum and fluoropyrimidine-based chemotherapy?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *Continue to 29*
❒ Subsequent treatment, *Continue to 29*

29. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to 31*
❒ Recurrent disease, *Continue to 31*
❒ Metastatic disease, *Continue to 31*
❒ Other, please specify. _____, *Continue to 30*

30. Is the patient a surgical candidate?

❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Does the patient have human epidermal growth factor receptor 2 (HER2) negative disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming HER2-negative disease.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 32*
❒ No, *Continue to 32*
❒ Unknown, *Continue to 32*

32. Does the tumor express programmed death ligand 1 (PD-L1) (greater than or equal to 1)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming PD-L1 tumor status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

33. Does the patient have nasopharyngeal cancer?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *Continue to 35*
❒ Other, please specify. _____, *Continue to 35*

35. Will the requested medication be used in combination with cisplatin and gemcitabine?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

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

37. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to 39*
❒ Inoperable disease, *Continue to 39*
❒ Advanced disease, *Continue to 39*
❒ Metastatic disease, *Continue to 39*
❒ Other, please specify. _____, *Continue to 39*

39. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) with ultra-hypermutated phenotype (e.g., tumor mutational burden (TMB) > 50 mut/Mb)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, polymerase epsilon/delta, and tumor mutational burden (TMB) status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

40. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. What is the clinical setting in which the requested medication will be used?
❒ As neoadjuvant therapy, *Continue to 42*
❒ Unresectable disease, *Continue to 42*
❒ Inoperable disease, *Continue to 42*
❒ Metastatic disease, *Continue to 42*
❒ Other, please specify. _____, *Continue to 42*

42. Will the requested medication be used to treat colon adenocarcinoma?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) with ultra-hypermutated phenotype (e.g., tumor mutational burden (TMB) > 50 mut/Mb)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, polymerase epsilon/delta, and tumor mutational burden (TMB) status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

44. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. What is the clinical setting in which the requested medication will be used?
❒ Advanced disease, *Continue to 46*
❒ Metastatic disease, *Continue to 46*
❒ Other, please specify. _____, *Continue to 46*

46. Will the requested medication be used to treat appendiceal adenocarcinoma?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) with ultra-hypermutated phenotype (e.g., tumor mutational burden (TMB) > 50 mut/Mb)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, polymerase epsilon/delta, and tumor mutational burden (TMB) status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

48. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. What is the clinical setting in which the requested medication will be used?
❒ As neoadjuvant therapy, *Continue to 50*

❒ Recurrent disease, *Continue to 50*
❒ Metastatic disease, *Continue to 50*
❒ Other, please specify. _____, *Continue to 50*

50. Will the requested medication be used to treat rectal adenocarcinoma?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) with ultra-hypermutated phenotype (e.g., tumor mutational burden (TMB) > 50 mut/Mb)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, polymerase epsilon/delta, and tumor mutational burden (TMB) status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *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