



Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

Electronically (4-5 minutes process time)	Phone (10-15 minutes process time)	Fax (24-72 hours process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}



Trelstar

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:

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> Ambulatory Surgical | <input type="checkbox"/> Home | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Office | <input type="checkbox"/> Pharmacy |

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. Trelstar with TGC SGM 1968-A- 09/2023.

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Exception Criteria Questions:

- A. Is the product being requested for the treatment of prostate cancer?
☐ Yes ☐ No *If No, skip to Clinical Criteria Questions*
- B. The preferred product for your patient's health plan is Eligard. Can the patient's treatment be switched to the preferred product?
If Yes, please obtain Form for preferred product and submit for corresponding PA. ☐ Yes ☐ No
- C. Is this request for continuation of therapy with the requested product? ☐ Yes ☐ No, *If No, skip to Question E*
- D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ☐ Yes ☐ No, *skip to Clinical Criteria Questions*
- E. Does the patient have a documented hypersensitivity to the preferred product (Eligard)? **ACTION REQUIRED: If Yes, please attach supporting chart note(s).** ☐ Yes ☐ No

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
☐ Prostate cancer, *Continue to 19*
☐ Gender dysphoria, *Continue to 2*
☐ Preservation of ovarian function, *Continue to 18*
☐ Breast cancer - ovarian suppression, *Continue to 22*
☐ Other, please specify _____, *No further questions*
2. Is the patient less than 18 years of age?
☐ Yes, *Continue to 3*
☐ No, *Continue to 4*
3. Is the requested medication prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?
☐ Yes, *Continue to 4*
☐ No, *Continue to 4*
4. Are the patient's comorbid conditions reasonably controlled?
☐ Yes, *Continue to 5*
☐ No, *Continue to 5*
5. Is the patient able to make an informed decision to engage in treatment?
☐ Yes, *Continue to 6*
☐ No, *Continue to 6*
6. Has the patient been educated on any contraindications and side effects to therapy?
☐ Yes, *Continue to 7*
☐ No, *Continue to 7*
7. Is the request for continuation of therapy?

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☐ Yes, *Continue to 13*

☐ No, *Continue to 8*

8. Has the patient been informed of fertility preservation options?

☐ Yes, *Continue to 9*

☐ No, *Continue to 9*

9. Is the requested medication prescribed for pubertal hormonal suppression in an adolescent patient?

☐ Yes, *Continue to 10*

☐ No, *Continue to 11*

10. Which Tanner stage of puberty has the patient reached?

☐ Tanner stage I, *No further questions*

☐ Tanner stage II, *No further questions*

☐ Tanner stage III, *No further questions*

☐ Tanner stage IV, *No further questions*

☐ Tanner stage V, *No further questions*

☐ Unknown, *No further questions*

11. Is the patient undergoing gender transition?

☐ Yes, *Continue to 12*

☐ No, *Continue to 12*

12. Will the patient receive the requested medication concomitantly with gender-affirming hormones?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

13. Has the patient been informed of fertility preservation options before the start of therapy?

☐ Yes, *Continue to 14*

☐ No, *Continue to 14*

14. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?

☐ Yes, *Continue to 15*

☐ No, *Continue to 16*

15. Which Tanner stage of puberty has the patient reached previously?

☐ Tanner stage I, *No further questions*

☐ Tanner stage II, *No further questions*

☐ Tanner stage III, *No further questions*

☐ Tanner stage IV, *No further questions*

☐ Tanner stage V, *No further questions*

☐ Unknown, *No further questions*

16. Is the patient undergoing gender transition?

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☐ Yes, *Continue to 17*

☐ No, *Continue to 17*

17. Will the patient receive the requested drug concomitantly with gender-affirming hormones?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

18. Is the patient premenopausal and undergoing chemotherapy?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

19. Is the patient currently receiving treatment with the requested medication?

☐ Yes, *Continue to 20*

☐ No, *No Further Questions*

20. Has the patient experienced clinical benefit to therapy while on the current regimen (e.g., serum testosterone less than 50 ng/dL)?

☐ Yes, *Continue to 21*

☐ No, *Continue to 21*

21. Has the patient experienced an unacceptable toxicity while on the current regimen?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

22. Is the patient currently receiving treatment with the requested medication?

☐ Yes, *Continue to 23*

☐ No, *Continue to 26*

23. Was the patient premenopausal at diagnosis?

☐ Yes, *Continue to 24*

☐ No, *Continue to 24*

24. Is the patient still undergoing treatment with endocrine therapy?

☐ Yes, *Continue to 25*

☐ No, *Continue to 25*

25. How many years has the patient received therapy with the requested medication?

☐ 5 years or greater, *No further questions*

☐ 4 years, *No further questions*

☐ 3 years, *No further questions*

☐ 2 years, *No further questions*

☐ 1 year or less, *No further questions*

26. Is the patient premenopausal?

☐ Yes, *Continue to 27*

☐ No, *Continue to 27*

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27. What is the patient's hormone receptor (HR) status? **ACTION REQUIRED:** Please attach documentation of hormone receptor status testing results.

- ☐ HR-positive **ACTION REQUIRED:** Submit supporting documentation, Continue to 28
☐ HR-negative **ACTION REQUIRED:** Submit supporting documentation, Continue to 28
☐ Unknown, Continue to 28

28. Is the patient at higher risk for recurrence (e.g., young age, high-grade tumor, lymph-node involvement)?

- ☐ Yes, Continue to 29
☐ No, Continue to 29

29. Will the requested drug be used in combination with endocrine therapy?

- ☐ 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)

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