



Unloxcyt

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*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit, CVS Caremark Specialty Programs Fax: 1-855-330-1720

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Site of Service Questions (SOS):

1. Where will this drug be administered?

- ☐ On-campus outpatient hospital, *Continue to 2*
- ☐ Off-campus outpatient hospital, *Continue to 2*
- ☐ Pharmacy, *skip to Criteria Questions*
- ☐ Physician office, *skip to Criteria Questions*
- ☐ Home infusion, *skip to Criteria Questions*
- ☐ Ambulatory surgical, *skip to Criteria Questions*

2. Is the patient less than 14 years of age?

- ☐ Yes, *skip to Criteria Questions*
- ☐ No, *Continue to 3*

3. Will the member's treatment plan for the requested drug be completed within the next 3 months? **Action Required:** If yes, please attach documentation of treatment plan end date.

- ☐ Yes, *skip to Criteria Questions*
- ☐ No, *Continue to 4*

4. 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 Criteria Questions*
- ☐ No, *Continue to 5*

5. 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 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 Criteria Questions*

- ☐ Yes, This is a continuation of existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to 6*

6. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, 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 Criteria Questions*
- ☐ No, *Continue to 7*

7. 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 Criteria Questions*
- ☐ No, *Continue to 8*

8. 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 Criteria Questions*
- ☐ No, *Continue to 9*

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9. 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 Criteria Questions*

☐ No, *Continue to 10*

10. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND does not have access to a caregiver? **Action Required:** If yes, please attach supporting clinical documentation.

☐ Yes, *skip to Criteria Questions*

☐ No, *Continue to 11*

11. 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 clinical documentation.

☐ Yes, *Continue to Clinical Criteria Questions*

☐ No, *Continue to Clinical Criteria Questions*

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Criteria Questions:

1. What is the diagnosis?

☐ Cutaneous squamous cell carcinoma (CSCC), *Continue to 2*

☐ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy?

☐ Yes, *Continue to 3*

☐ No, *Continue to 3*

3. Is the patient currently receiving the requested medication?

☐ Yes, *Continue to 4*

☐ No, *Continue to 5*

4. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

5. What is the clinical setting in which the requested medication will be used?

☐ Metastatic disease, *Continue to 6*

☐ Locally advanced disease, *Continue to 6*

☐ Other, please specify. _____, *Continue to 6*

6. Is the patient a candidate for curative surgery or curative radiation?

☐ 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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