Zoladex

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 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 Zoladex with Other Ind SGM 1918-A – 06.2025.

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

Criteria Questions:

1. What dose of the requested drug is being prescribed?

❒ Zoladex 3.6 mg, *Continue to 2*

❒ Zoladex 10.8 mg, *Continue to 3*

2. What is the diagnosis?

❒ Prostate cancer, *Continue to 4*

❒ Breast cancer, *Continue to 4*

❒ Epithelial ovarian, fallopian tube, primary peritoneal cancer or malignant sex cord-stromal tumor (3.6 mg dose only), *Continue to 4*

❒ Dysfunctional uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only), *Continue to 19*

❒ Chronic anovulatory uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only), *Continue to 19*

❒ Endometriosis (3.6 mg dose only), *Continue to 22*

❒ Preservation of ovarian function (3.6 mg dose only), *Continue to 23*

❒ Recurrent menstrual related attacks in acute porphyria (3.6 mg dose only), *Continue to 40*

❒ Gender dysphoria, *Continue to 24*

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

3. What is the diagnosis?

❒ Prostate cancer, *Continue to 5*

❒ Breast cancer, *Continue to 5*

❒ Gender dysphoria, *Continue to 24*

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

4. Is this a request for continuation of therapy with Zoladex 3.6 mg?

❒ Yes, *Continue to 10*

❒ No, *Continue to 15*

5. Is this a request for continuation of therapy with Zoladex 10.8 mg?

❒ Yes, *Continue to 6*

❒ No, *Continue to 14*

6. What is the diagnosis?

❒ Prostate cancer, *Continue to 7*

❒ Breast cancer, *Continue to 8*

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

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

8. Has the patient experienced clinical benefit while on the current regimen?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Has the patient experienced an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. What is the diagnosis?

❒ Prostate cancer, *Continue to 11*

❒ Breast cancer, *Continue to 12*

❒ Epithelial ovarian, fallopian tube, primary peritoneal cancer or malignant sex cord-stromal tumor, *Continue to 12*

11. 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 13*
❒ No, *Continue to 13*

12. Has the patient experienced clinical benefit while on the current regimen?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient experienced an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. What is the diagnosis?

❒ Prostate cancer, *No further questions*

❒ Breast cancer, *Continue to 16*

15. What is the diagnosis?

❒ Prostate cancer, *No further questions*

❒ Breast cancer, *Continue to 16*

❒ Epithelial ovarian, fallopian tube, primary peritoneal cancer or malignant sex cord-stromal tumor, *Continue to 17*

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

❒ HR-positive ***ACTION REQUIRED***: Submit supporting documentation, *No further questions*

❒ HR-negative ***ACTION REQUIRED***: Submit supporting documentation, *No further questions*

❒ Unknown, *No further questions*

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

❒ Persistent disease, *Continue to 18*

❒ Recurrent disease, *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

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

19. Will the requested drug be used as an endometrial thinning agent prior to endometrial ablation or resection for dysfunctional uterine bleeding?
❒ Yes, *No Further Questions*
❒ No, *Continue to 20*

20. Will the requested drug be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. For how many months has the patient already received the requested drug for this indication?
_____ months, *No further questions*

22. For how many months has the patient already received the requested drug for this indication?
_____ months, *No further questions.*

23. Is the patient premenopausal and undergoing chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Is the patient less than 18 years of age?
❒ Yes, *Continue to 25*
❒ No, *Continue to 26*

25. Is the requested drug 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 26*
❒ No, *Continue to 26*

26. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is the patient able to make an informed decision to engage in treatment?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the request for continuation of therapy?
❒ Yes, *Continue to 35*
❒ No, *Continue to 30*

30. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 32*
❒ No, *Continue to 33*

32. Which Tanner stage of puberty has the patient reached?
❒ Tanner stage 1, *No further questions*
❒ Tanner stage 2, *No further questions*
❒ Tanner stage 3, *No further questions*
❒ Tanner stage 4, *No further questions*
❒ Tanner stage 5, *No further questions*
❒ Unknown, *No further questions*

33. Is the patient undergoing gender transition?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

35. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is the requested drug prescribed for pubertal hormonal suppression in an adolescent patient?
❒ Yes, *Continue to 37*
❒ No, *Continue to 38*

37. Which Tanner stage of puberty has the patient reached previously?
❒ Tanner stage 1, *No further questions*
❒ Tanner Stage 2, *No further questions*
❒ Tanner stage 3, *No further questions*
❒ Tanner stage 4, *No further questions*
❒ Tanner stage 5, *No further questions*
❒ Unknown, *No further questions*

38. Is the patient undergoing gender transition?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

40. Is the requested drug being prescribed by, or in consultation with, a provider experienced in the management of porphyrias?
❒ 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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