



## Halaven

### 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.

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**Patient Name:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
**Patient's Date of Birth:** \_\_\_\_\_  
**NPI#:** \_\_\_\_\_  
**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**

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. Eribulin-Halaven SGM 1893-A – 6/2024.

**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](http://www.caremark.com)**

**Criteria Questions:**

1. What is the patient's diagnosis?

- ☐ Breast cancer, *Continue to 2*
- ☐ Liposarcoma, *Continue to 2*
- ☐ Pleomorphic rhabdomyosarcoma, *Continue to 2*
- ☐ Retroperitoneal/intra-abdominal soft tissue sarcoma, *Continue to 2*
- ☐ Extremity/body wall or head/neck soft tissue sarcoma, *Continue to 2*
- ☐ Other, please specify. \_\_\_\_\_, *Continue to 2*

2. Is this a request for continuation of therapy with the requested drug?

- ☐ Yes, *Continue to 3*
- ☐ No, *Continue to 4*

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

- ☐ Yes, *No Further Questions*
- ☐ No, *No Further Questions*

4. What is the diagnosis?

- ☐ Breast cancer, *Continue to 5*
- ☐ Liposarcoma, *Continue to 9*
- ☐ Pleomorphic rhabdomyosarcoma, *Continue to 9*
- ☐ Retroperitoneal/intra-abdominal soft tissue sarcoma, *Continue to 9*
- ☐ Extremity/body wall or head/neck soft tissue sarcoma, *Continue to 9*

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

- ☐ Recurrent disease, *Continue to 6*
- ☐ Metastatic disease, *Continue to 6*
- ☐ No response to preoperative systemic therapy, *Continue to 6*
- ☐ Other, please specify. \_\_\_\_\_, *Continue to 6*

6. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED:*** Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) testing results.

- ☐ HER2-positive ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 7*
- ☐ HER2-negative ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 8*
- ☐ Unknown, *No further questions*

7. Will the requested drug be given in combination with trastuzumab (Herceptin) or margetuximab (Margenza)?

- ☐ Yes, *No Further Questions*
- ☐ No, *No Further Questions*

8. Will the requested drug be given as a single agent?

- ☐ Yes, *No Further Questions*
- ☐ No, *No Further Questions*

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9. Will the requested drug be given as single-agent 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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