Abraxane

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

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. CareFirst Abraxane SGM 1669-A – 08/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Pancreatic adenocarcinoma, *Continue to 2*

❒ Breast cancer, *Continue to 2*

❒ Non-small cell lung cancer (NSCLC), *Continue to 2*

❒ Cutaneous melanoma, *Continue to 2*

❒ Epithelial ovarian cancer, *Continue to 2*

❒ Fallopian tube cancer, *Continue to 2*

❒ Primary peritoneal cancer, *Continue to 2*

❒ Kaposi sarcoma, *Continue to 2*

❒ Endometrial carcinoma, *Continue to 2*

❒ Intrahepatic cholangiocarcinoma, *Continue to 2*

❒ Extrahepatic cholangiocarcinoma, *Continue to 2*

❒ Gallbladder cancer, *Continue to 2*

❒ Uveal melanoma, *Continue to 2*

❒ Small bowel adenocarcinoma, *Continue to 2*

❒ Ampullary adenocarcinoma, *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Bladder cancer, *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 unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Pancreatic adenocarcinoma, *Continue to 5*

❒ Breast cancer, *Continue to 19*

❒ Non-small cell lung cancer (NSCLC), *Continue to 21*

❒ Cutaneous melanoma, *Continue to 8*

❒ Epithelial ovarian cancer, *Continue to 11*

❒ Fallopian tube cancer, *Continue to 11*

❒ Primary peritoneal cancer, *Continue to 11*

❒ Kaposi sarcoma, *No further questions*

❒ Endometrial carcinoma, *Continue to 6*

❒ Intrahepatic cholangiocarcinoma, *Continue to 13*

❒ Extrahepatic cholangiocarcinoma, *Continue to 13*

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❒ Gallbladder cancer, *Continue to 13*

❒ Uveal melanoma, *Continue to 15*

❒ Small bowel adenocarcinoma, *Continue to 17*

❒ Ampullary adenocarcinoma, *Continue to 23*

❒ Cervical cancer, *Continue to 24*

❒ Bladder cancer, *Continue to 27*

5. Will the requested drug be used in combination with gemcitabine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *Continue to 7*

❒ Subsequent therapy, *Continue to 7*

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

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

❒ Unresectable disease, *Continue to 9*

❒ Metastatic disease, *Continue to 9*

❒ Other, please specify. _____, *Continue to 9*

9. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *Continue to 10*

❒ Subsequent therapy, *Continue to 10*

10. Will the requested drug be used in any of the following regimens?

❒ As a single-agent, *No further questions*

❒ In combination with carboplatin, *No further questions*

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

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

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Other, please specify. _____, *Continue to 12*

12. Will the requested drug be used as a paclitaxel substitute due to hypersensitivity reactions to paclitaxel?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Unresectable disease, *Continue to 14*

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❒ Resected gross residual (R2) disease, *Continue to 14*

❒ Metastatic disease, *Continue to 14*

❒ Other, please specify. _____, *Continue to 14*

14. Will the requested medication be used in combination with gemcitabine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Metastatic disease, *Continue to 16*

❒ Unresectable disease, *Continue to 16*

❒ Other, please specify. _____, *Continue to 16*

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

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

❒ Advanced disease, *Continue to 18*

❒ Metastatic disease, *Continue to 18*

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

18. Will the requested drug be used in any of the following regimens?

❒ As a single agent, *No further questions*

❒ In combination with gemcitabine, *No further questions*

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

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

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Following no response to preoperative systemic therapy, *No further questions*

❒ Other, please specify. _____, *Continue to 20*

20. Will the requested drug be used as a paclitaxel or docetaxel substitute due to hypersensitivity reactions or contraindication to standard hypersensitivity premedications?

❒ Yes, due to hypersensitive reactions, *No further questions*

❒ Yes, contraindication to standard hypersensitivity premedications, *No further questions*

❒ No, *No further questions*

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

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

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❒ Advanced disease, *No further questions*

❒ Other, please specify. _____, *Continue to 22*

22. Will the requested drug be used as a paclitaxel or docetaxel substitute due to hypersensitivity reactions or contraindication to standard hypersensitivity premedications?

❒ Yes, due to hypersensitive reactions, *No further questions*

❒ Yes, contraindication to standard hypersensitivity premedications, *No further questions*

❒ No, *No further questions*

23. Will the requested drug be used in combination with gemcitabine?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ Persistent disease, *Continue to 25*

❒ Recurrent disease, *Continue to 25*

❒ Metastatic disease, *Continue to 25*

❒ Other, please specify. _____, *Continue to 25*

25. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *Continue to 26*

❒ Subsequent therapy, *Continue to 26*

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

27. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *Continue to 28*

❒ Subsequent therapy, *Continue to 28*

28. Does the patient have platinum-resistant disease?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

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

❒ Locally advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *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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