PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 9/6/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Non-small cell lung cancer (NSCLC) (including brain metastases from non-small cell lung cancer) (If checked, go to 2) ☐
   - Anaplastic large cell lymphoma (ALCL) (If checked, go to 7) ☐
   - Large B-cell lymphoma (LBCL) (If checked, go to 7) ☐
   - Inflammatory myofibroblastic tumor (IMT) (If checked, go to 7) ☐
   - Erdheim-Chester disease (ECD) (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
3. Is this request for continuation of adjuvant treatment? **Y** ☐ **N** ☐
4. Is there evidence of unacceptable toxicity or disease recurrence while on the current regimen? **Y** ☐ **N** ☐
5. How many continuous months of treatment has the patient received with the requested drug?
   - Greater than or equal to 24 months (If checked, no further questions) ☐
   - 23 months (If checked, no further questions) ☐
   - 22 months (If checked, no further questions) ☐
   - 21 months (If checked, no further questions) ☐
   - 20 months (If checked, no further questions) ☐
   - 19 months (If checked, no further questions) ☐
   - 18 months (If checked, no further questions) ☐
   - 17 months (If checked, no further questions) ☐
   - 16 months (If checked, no further questions) ☐

15 months (If checked, no further questions) ☐

14 months (If checked, no further questions) ☐

13 months (If checked, no further questions) ☐

12 months or less (If checked, no further questions) ☐

6. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

7. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

8. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

9. What is the diagnosis?

Non-Small Cell Lung Cancer (NSCLC) (If checked, go to 10) ☐

Anaplastic large cell lymphoma (ALCL) (If checked, go to 16) ☐

Large B-cell lymphoma (LBCL) (If checked, go to 19) ☐

Inflammatory myofibroblastic tumor (IMT) (If checked, go to 21) ☐

Erdheim-Chester disease (ECD) (If checked, go to 25) ☐

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

Adjuvant treatment (If checked, go to 12) ☐

Recurrent disease (If checked, go to 11) ☐

Advanced disease (If checked, go to 11) ☐

Metastatic disease (If checked, go to 11) ☐

Other, please specify. (If checked, no further questions) ☐

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11. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, go to 15) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

12. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, go to 13) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

13. Is the tumor 4 cm or greater or is the disease node positive? **Y** ☐ **N** ☐

14. Will the requested drug be used following complete tumor resection? **Y** ☐ **N** ☐

15. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

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

Relapsed/refractory disease (If checked, go to 17) ☐

Initial palliative therapy (If checked, go to 17) ☐

Other, please specify. (If checked, no further questions) ☐

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17. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, go to 18) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

18. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

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

Relapsed/refractory disease (If checked, go to 20) ☐

Other, please specify. (If checked, no further questions) ☐

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20. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

21. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, go to 22) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

22. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

23. Which of the following applies to the patient?

Soft tissue sarcoma (not including uterine sarcoma) (If checked, no further questions) ☐

Uterine sarcoma (If checked, go to 24) ☐

Other, please specify. (If checked, no further questions) ☐

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

Recurrent disease (If checked, no further questions) ☐

Advanced disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

Inoperable disease (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) ☐

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

Relapsed/refractory disease (If checked, go to 26) ☐

Symptomatic disease (If checked, go to 26) ☐

Other, please specify. (If checked, no further questions) ☐

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26. Is the tumor positive for an anaplastic lymphoma kinase (ALK) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results demonstrating anaplastic lymphoma kinase (ALK) mutation.

Yes (If checked, go to 27) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

27. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date