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 4) ☐
   - Inflammatory myofibroblastic tumor (IMT) (If checked, go to 4) ☐
   - Erdheim-Chester disease (ECD) (If checked, go to 4) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
6. What is the diagnosis?
   - Anaplastic large cell lymphoma (ALCL) (If checked, go to 17) ☐
   - Inflammatory myofibroblastic tumor (IMT) (If checked, go to 10) ☐
   - Erdheim-Chester disease (ECD) (If checked, go to 14) ☐
7. What is the clinical setting in which the requested medication will be used?
   - Recurrent disease (If checked, go to 8) ☐
   - Advanced disease (If checked, go to 8) ☐
   - Metastatic disease (If checked, go to 8) ☐
   - Other, please specify. (If checked, no further questions) ☐

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8. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

9. 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

10. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

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 12) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

12. Which of the following type of soft tissue sarcoma applies to the patient?
   - Uterine sarcoma (If checked, go to 13) ☐
   - Soft tissue sarcoma (not including uterine sarcoma) (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

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13. What is the clinical setting in which the requested medication will be used?
   - Advanced disease (If checked, no further questions) ☐
   - Recurrent 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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14. What is the clinical setting in which the requested medication will be used?
   - Relapsed/refractory disease (If checked, go to 15) ☐
   - Symptomatic disease (If checked, go to 15) ☐
   - Other, please specify. (If checked, no further questions) ☐

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15. 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 16) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

16. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

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

Treatment as initial palliative therapy (If checked, go to 19) ☐

Relapsed/refractory disease (If checked, go to 19) ☐

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

_____

19. Will the requested medication 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