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 patient's diagnosis?
   - Non-small cell lung cancer (NSCLC) (If checked, go to 2) ☐
   - Solid tumors with NTRK gene fusion (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the disease ROS1 positive? ACTION REQUIRED: If Yes, attach chart notes or test results confirming ROS1 status.
   - Yes (If checked, go to 3) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

3. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

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

5. 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) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

6. Has laboratory testing (e.g., next-generation sequencing [NGS] or fluorescence in situ hybridization [FISH]) demonstrated that the patient's tumor has a neurotrophic tyrosine receptor kinase (NTRK) gene fusion? ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming NTRK gene fusion.
   - Yes (If checked, go to 7) ☐
   - No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

7.	Is the patient currently receiving treatment with the requested drug?	**Y** ☐	**N** ☐
8.	Is there evidence of disease progression or unacceptable toxicity while on the current regimen?	**Y** ☐	**N** ☐
9.	Is the patient 12 years of age and older?	**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.

_____

Prescriber (Or Authorized) Signature and Date