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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:** 2/20/2026
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?
 - Low-Grade Serous Ovarian Cancer (LGSOC) (If checked, go to 2)
 - 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 there evidence of disease progression while on the current regimen? **Y** **N**

5. What is the patient's KRAS mutation status? ACTION REQUIRED: If Positive, attach chart note(s) or test results confirming KRAS mutation status.
 - Positive (If checked, go to 6)
 - Negative (If checked, no further questions)
 - Unknown (If checked, no further questions)
 - ACTION REQUIRED: Submit supporting documentation

6. What is the clinical setting in which the requested medication will be used?
 - Recurrent disease (If checked, go to 7)
 - Other, please specify. (If checked, no further questions)
 - _____

7. Has the patient received prior systemic therapy? **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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.