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?
   - Urothelial carcinoma - Bladder cancer (If checked, go to 2) ☐
   - Urothelial carcinoma - Primary carcinoma of the urethra (If checked, go to 2) ☐
   - Urothelial carcinoma - Upper genitourinary tract tumors (If checked, go to 2) ☐
   - Urothelial carcinoma - Urothelial carcinoma of the prostate (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____
2. Is the patient currently receiving therapy with the requested drug? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
5. What is the place in therapy in which the requested drug will be used?
   - First-line treatment (If checked, no further questions) ☐
   - Subsequent treatment (If checked, go to 6) ☐
6. Does the patient have a susceptible fibroblast growth factor receptor (FGFR)3 or FGFR2 genetic alterations? ACTION REQUIRED: If Yes, attach chart note(s) or test results of FGFR status.
   - Yes (If checked, go to 7) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation
7. What is the diagnosis?
   - Urothelial carcinoma - Bladder cancer (If checked, go to 8) ☐
   - Urothelial carcinoma - Primary carcinoma of the urethra (If checked, go to 11) ☐

Urothelial carcinoma - Upper genitourinary tract tumors (If checked, go to 12) ☐

Urothelial carcinoma - Urothelial carcinoma of the prostate (If checked, go to 13) ☐

8. Will the drug be used for either of the following: a) metastatic or local recurrence post-cystectomy, b) muscle invasive local recurrence or persistent disease in a preserved bladder? **Y** ☐ **N** ☐

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

Stage II disease (If checked, go to 10) ☐

Locally advanced disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

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

_____

10. Is the tumor present following reassessment of tumor status 2-3 months after primary treatment with concurrent bladder preserving chemoradiotherapy and maximal transurethral resection of bladder tumor (TURBT)? **Y** ☐ **N** ☐

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

Locally advanced disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

Recurrent disease (If checked, no further questions) ☐

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

_____

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

Locally advanced disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

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

_____

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

Locally advanced disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

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

_____

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