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?
   - Medullary thyroid cancer (If checked, go to 2) ☐
   - Papillary thyroid cancer (If checked, go to 2) ☐
   - Follicular thyroid cancer (If checked, go to 2) ☐
   - Oncocytic/Hurthle cell thyroid cancer (If checked, go to 2) ☐
   - Non-small cell lung cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

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

4. What is the diagnosis?
   - Medullary thyroid cancer (If checked, no further questions) ☐
   - Papillary thyroid cancer (If checked, go to 5) ☐
   - Follicular thyroid cancer (If checked, go to 5) ☐
   - Oncocytic/Hurthle cell thyroid cancer (If checked, go to 5) ☐
   - Non-small cell lung cancer (If checked, go to 7) ☐

5. Is the thyroid carcinoma amenable to radioactive iodine (RAI) therapy? **Y** ☐ **N** ☐

6. Has the disease progressed after treatment with lenvatinib or sorafenib? **Y** ☐ **N** ☐

7. What is the clinical setting in which the requested drug will be used?
   - Recurrent disease (If checked, go to 8) ☐
   - Advanced disease (If checked, go to 8) ☐

Metastatic disease (If checked, go to 8) ☐

None of the above (If checked, no further questions) ☐

8. Has the patient tested positive for RET gene rearrangements? ACTION REQUIRED: Please submit chart notes or test results of RET gene rearrangement status.

Yes (If checked, go to 9) ☐

No (If checked, no further questions) ☐

Unknown or not available (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

9. Has the disease progressed on therapy with a RET rearrangement positive-targeted regimen? **Y** ☐ **N** ☐

10. 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.

_____

Prescriber (Or Authorized) Signature and Date