PA Request Criteria

00-000000000

237574

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:** 1/23/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
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) (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 the disease anaplastic lymphoma kinase (ALK)-positive? ACTION REQUIRED: If Yes, attach chart documentation or test results of ALK mutation status.
   - Yes (If checked, go to 5) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

5. What is the clinical setting in which the requested drug will be used?
   - Advanced disease (If checked, go to 6) ☐
   - Metastatic disease (If checked, go to 6) ☐
   - Recurrent disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

6. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

7. Which of the following applies to the patient's disease?
   - The patient has not previously received an ALK-inhibitor (If checked, no further questions) ☐
   - The patient has experienced intolerance with crizotinib (Xalkori) (If checked, no further questions) ☐

The patient has experienced disease progression with crizotinib (Xalkori) (If checked, no further questions) ☐

None of the above (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.

_____

Prescriber (Or Authorized) Signature and Date