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:** 11/4/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

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-metastatic castration-resistant prostate cancer (If checked, go to 2) ☐
   - Metastatic castration-sensitive prostate cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
3. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Will the requested medication be used in combination with a second-generation oral anti-androgen (e.g., enzalutamide [Xtandi]) or an oral androgen metabolism inhibitor (e.g., abiraterone acetate [Zytiga])? **Y** ☐ **N** ☐
5. Has the patient had a bilateral orchiectomy? **Y** ☐ **N** ☐
6. Will the requested medication be administered with a gonadotropin-releasing hormone (GnRH) agonist or degarelix? **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

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