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:** 9/9/2024
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-small cell lung cancer (If checked, go to 2) ☐
   - Anaplastic thyroid cancer (If checked, go to 8) ☐
   - Thyroid cancer (If checked, go to 13) ☐
   - 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 or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. What is the clinical setting in which the requested medication will be used?
   - Recurrent disease (If checked, go to 5) ☐
   - Advanced disease (If checked, go to 5) ☐
   - Metastatic disease (If checked, go to 5) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
5. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
6. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach chart note(s) or test results for RET gene fusion.
   - Yes (If checked, go to 7) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
7. Has the patient experienced disease progression on therapy with a RET rearrangement positive-targeted regimen? **Y** ☐ **N** ☐
8. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

10. What is the clinical setting in which the requested medication will be used?
    - Stage IV disease (If checked, go to 11) ☐
    - Other, please specify. (If checked, no further questions) ☐

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11. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach chart note(s) or test results for RET gene fusion.
    - Yes (If checked, go to 12) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

12. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

13. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

15. Which of the following applies to the patient's disease?
    - Follicular thyroid cancer (If checked, go to 16) ☐
    - Oncocytic thyroid cancer (If checked, go to 16) ☐
    - Papillary thyroid cancer (If checked, go to 16) ☐
    - Other, please specify. (If checked, no further questions) ☐

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16. What is the clinical setting in which the requested medication will be used?
    - Advanced disease (If checked, go to 17) ☐
    - Metastatic disease (If checked, go to 17) ☐
    - Other, please specify. (If checked, no further questions) ☐

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17. Is the disease amenable to radioactive iodine therapy (RAI)? **Y** ☐ **N** ☐

18. What is the patient's age (in years)?
    - Less than 12 years old (If checked, no further questions) ☐
    - Greater than or equal to 12 years old (If checked, go to 19) ☐

19. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach chart note(s) or test results for RET gene fusion.
    - Yes (If checked, no further questions) ☐
    - No (If checked, no further questions) ☐
    - Unknown (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