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:** 6/13/2025
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?
   - Breast cancer (If checked, go to 2) ☐
   - Soft tissue sarcoma (retroperitoneal liposarcoma) (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

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

4. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐

5. What is the prescribed regimen?
   - The requested drug with an aromatase inhibitor (e.g., anastrozole [Arimidex], exemestane [Aromasin], letrozole [Femara]) (If checked, go to 6) ☐
   - The requested drug with fulvestrant (Faslodex) (If checked, go to 6) ☐
   - The requested drug in combination with inavolisib (Itovebi) and fulvestrant (Faslodex) (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

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6. What is the clinical setting in which the requested drug will be used?
   - Recurrent disease (If checked, go to 10) ☐
   - Advanced disease (If checked, go to 10) ☐
   - Metastatic disease (If checked, go to 10) ☐
   - Other, please specify. (If checked, no further questions) ☐

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7. Is the disease endocrine-resistant? **Y** ☐ **N** ☐

8. Does the patient have a documented PIK3CA mutation? ACTION REQUIRED: If Yes, please attach laboratory test results confirming mutation status.

- Yes (If checked, go to 9) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

- Locally advanced disease (If checked, go to 10) ☐
- Metastatic disease (If checked, go to 10) ☐
- Recurrent disease (If checked, go to 10) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

10. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: Please attach chart note(s) or test results of hormone receptor (HR) status.

- HR-Positive (If checked, go to 11) ☐
- HR-Negative (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

11. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

- HER2-Positive (If checked, no further questions) ☐
- HER2-Negative (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

13. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

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

15. Does the patient have unresectable retroperitoneal liposarcoma? **Y** ☐ **N** ☐

16. What is the histology?

- Well-differentiated (If checked, go to 17) ☐
- Dedifferentiated (If checked, go to 17) ☐
- Myxoid (If checked, no further questions) ☐
- Pleomorphic (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

17. 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

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