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:** 7/17/2024
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 patient's diagnosis?
   - Breast cancer (If checked, go to 2) ☐
   - Endometrial carcinoma (If checked, go to 2) ☐
   - 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 or disease progression while on the current regimen? **Y** ☐ **N** ☐

4. What is the diagnosis?
   - Breast cancer (If checked, go to 5) ☐
   - Endometrial carcinoma (If checked, go to 8) ☐

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

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6. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: Attach documentation of hormone receptor (HR) status.
   - HR-Positive (If checked, go to 7) ☐
   - HR-Negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

7. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ACTION REQUIRED: Attach documentation 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

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

- Advanced disease (If checked, go to 9) ☐
- Recurrent disease (If checked, go to 9) ☐
- Metastatic disease (If checked, go to 9) ☐
- Other, please specify. (If checked, no further questions) ☐

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9. What is the patient's estrogen receptor (ER) status? ACTION REQUIRED: Attach documentation of estrogen receptor (ER) status.

- ER-positive (If checked, no further questions) ☐
- ER-negative (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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.

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Prescriber (Or Authorized) Signature and Date