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:** 7/2/2026
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?
   - Carcinosarcoma (malignant mixed Mullerian tumors) (If checked, go to 2) ☐
   - Clear cell carcinoma of the ovary (If checked, go to 2) ☐
   - Epithelial ovarian cancer (If checked, go to 2) ☐
   - Fallopian tube cancer (If checked, go to 2) ☐
   - Grade 1 endometrioid carcinoma (If checked, go to 2) ☐
   - Low-grade serous carcinoma (If checked, go to 2) ☐
   - Primary peritoneal cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested medication? **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 clinical setting in which the requested drug will be used?
   - Platinum-resistant persistent disease (If checked, go to 6) ☐
   - Platinum-resistant recurrent disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

6. Has the patient received at least one prior systemic treatment regimen which included bevacizumab? **Y** ☐ **N** ☐
7. Will the requested drug be used in combination with nab-paclitaxel (Abraxane)? **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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