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?
   - Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer, and rectal cancer) (If checked, go to 2) ☐
   - Esophagogastric junction, gastric or gastroesophageal junction adenocarcinoma (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 or disease progression while on the current regimen? **Y** ☐ **N** ☐

4. What is the diagnosis?
   - Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer, and rectal cancer) (If checked, go to 5) ☐
   - Esophagogastric junction, gastric or gastroesophageal junction adenocarcinoma (If checked, go to 11) ☐

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

   _____

6. Has the patient progressed on previous treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (with or without bevacizumab)? **Y** ☐ **N** ☐

7. Does the patient have a contraindication or intolerance to fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (with or without bevacizumab)? **Y** ☐ **N** ☐

8. Will the requested medication be used to treat rectal cancer, appendiceal adenocarcinoma, anal adenocarcinoma, or left-sided colon cancer that is RAS wild-type? **Y** ☐ **N** ☐

9. Has the patient progressed on previous treatment with an anti-epidermal growth factor receptor (EGFR) therapy (e.g., cetuximab [Erbitux], panitumumab [Vectibix])? **Y** ☐ **N** ☐

10. Does the patient have a contraindication or intolerance to anti-epidermal growth factor receptor (EGFR) therapy (e.g., cetuximab [Erbitux], panitumumab [Vectibix])? **Y** ☐ **N** ☐

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

12. Has the patient been previously treated with at least 2 prior lines of chemotherapy? **Y** ☐ **N** ☐

13. Is the patient a candidate for surgery? **Y** ☐ **N** ☐

14. What is the clinical setting in which the requested medication will be used?

- Metastatic disease (If checked, no further questions) ☐
- Recurrent disease (If checked, no further questions) ☐
- Unresectable locally advanced disease (If checked, no further questions) ☐
- Other, please specify. (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.

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Prescriber (Or Authorized) Signature and Date