PA Request Criteria

00-000000000

214731

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:** 10/10/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

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 (NSCLC) (If checked, go to 2) ☐
   - Pancreatic Adenocarcinoma (If checked, go to 2) ☐
   - Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 2) ☐
   - Ampullary Adenocarcinoma (If checked, go to 2) ☐
   - 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 diagnosis?
   - Non-small cell lung cancer (NSCLC) (If checked, go to 5) ☐
   - Pancreatic adenocarcinoma (If checked, go to 9) ☐
   - Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 13) ☐
   - Ampullary Adenocarcinoma (If checked, go to 17) ☐

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) ☐
   - 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 therapy? **Y** ☐ **N** ☐

7. Does the patient's cancer have a KRAS G12C mutation? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results confirming KRAS G12C mutation status.

- Yes (If checked, go to 8) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

8. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

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

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

_____

10. Is the tumor or plasma specimen positive for the KRAS G12C mutation? ACTION REQUIRED, If Yes, please attach supporting chart note(s) or test results confirming KRAS G12C mutation status.

- Yes (If checked, go to 11) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

11. What is the patient's Eastern Cooperative Oncology Group (ECOG) performance status?

- 0-2 (If checked, go to 12) ☐
- 3 or greater (If checked, no further questions) ☐

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

13. Is the tumor or plasma specimen positive for the KRAS G12C mutation? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results confirming KRAS G12C mutation status.

- Yes (If checked, go to 14) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐
- ACTION REQUIRED: Submit supporting documentation

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

- Advanced disease (If checked, go to 15) ☐
- Metastatic disease (If checked, go to 15) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

15. How will the requested medication be used?

- As a single agent (If checked, go to 16) ☐
- In combination with cetuximab (Erbitux) (If checked, go to 16) ☐
- In combination with panitumumab (Vectibix) (If checked, go to 16) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

16. Has the patient been previously treated with chemotherapy? **Y** ☐ **N** ☐

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

- Progressive disease (If checked, go to 18) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

18. Is the tumor or plasma specimen positive for the KRAS G12C mutation? ACTION REQUIRED, If Yes, please attach supporting chart note(s) or test results confirming KRAS G12C mutation status.

- Yes (If checked, go to 19) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19. Will the requested medication 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