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:** 10/10/2024
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?
   - Cholangiocarcinoma (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 medication? **Y** ☐ **N** ☐

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

4. What is the clinical setting in which the requested medication will be used?
   - Unresectable disease (If checked, go to 5) ☐
   - Resected gross residual (R2) disease (If checked, go to 5) ☐
   - Locally advanced disease (If checked, go to 5) ☐
   - Metastatic disease (If checked, go to 5) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

5. Does the disease have a fibroblast growth factor receptor 2 (FGFR2) fusion or rearrangement? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for fibroblast growth factor receptor 2 (FGFR2) fusion or rearrangement.
   - Yes (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

6. What is the place in therapy in which the requested medication will be used?
   - First-line treatment (If checked, no further questions) ☐
   - Subsequent treatment (If checked, go to 7) ☐

7. 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

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