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:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **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 patient's diagnosis?
   - Breast cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____
2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity 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?
   - 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) ☐
   _____
6. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: Please attach documentation of hormone receptor (HR) status.
   - Positive (If checked, go to 7) ☐
   - Negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
7. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.
   - Positive (If checked, no further questions) ☐
   - Negative (If checked, go to 8) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8. Does the patient have a documented PIK3CA mutation? ACTION REQUIRED: If Yes, please attach laboratory test results.

Yes (If checked, go to 9) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

9. Will the requested drug be used in combination with fulvestrant? **Y** ☐ **N** ☐

10. Has the disease progressed during or following treatment with an endocrine-based regimen? **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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