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?
   - Non-small cell lung cancer (including brain metastases from NSCLC) (If checked, go to 2) ☐
   - Thyroid cancer (If checked, go to 2) ☐
   - Solid tumors (If checked, go to 2) ☐
   - Erdheim-Chester Disease (ECD) (If checked, go to 2) ☐
   - Rosai-Dorfman Disease (RDD) (If checked, go to 2) ☐
   - Langerhans Cell Histiocytosis (LCH) (If checked, go to 2) ☐
   - Occult primary cancer (If checked, go to 2) ☐
   - Gallbladder cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

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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 (including brain metastases from NSCLC) (If checked, go to 5) ☐
   - Thyroid cancer (If checked, go to 8) ☐
   - Solid tumors (If checked, go to 15) ☐
   - Erdheim-Chester Disease (ECD) (If checked, go to 22) ☐
   - Rosai-Dorfman Disease (RDD) (If checked, go to 22) ☐
   - Langerhans Cell Histiocytosis (LCH) (If checked, go to 26) ☐
   - Occult primary cancer (If checked, go to 28) ☐
   - Gallbladder cancer (If checked, go to 32) ☐

5. What is the clinical setting in which the requested medication 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) ☐

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

7. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.

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

ACTION REQUIRED: Submit supporting documentation

8. Does the patient have a rearranged during transfection (RET) gene mutation? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene mutation.

- Yes (If checked, go to 9) ☐
- No (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

9. Which of the following applies to the patient?

- Anaplastic thyroid cancer (If checked, go to 10) ☐
- Medullary thyroid cancer (If checked, go to 12) ☐
- Follicular thyroid carcinoma (If checked, go to 13) ☐
- oncocytic/Hurthle cell thyroid carcinoma (If checked, go to 13) ☐
- Papillary thyroid carcinoma (If checked, go to 13) ☐
- Other, please specify. (If checked, no further questions) ☐

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

- Locoregional disease (If checked, go to 11) ☐
- Metastatic disease (If checked, go to 11) ☐
- Other, please specify. (If checked, no further questions) ☐

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

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

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

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

Progressive/symptomatic disease (If checked, go to 14) ☐

Advanced disease (If checked, go to 14) ☐

Metastatic disease (If checked, go to 14) ☐

Other, please specify. (If checked, no further questions) ☐

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14. Is the disease amenable to radioactive iodine therapy? **Y** ☐ **N** ☐

15. Which of the following applies to the patient disease?

Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer (If checked, go to 16) ☐

Pancreatic adenocarcinoma (If checked, go to 16) ☐

Cervical cancer (If checked, go to 16) ☐

Small bowel adenocarcinoma (If checked, go to 16) ☐

Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (If checked, go to 16) ☐

Hepatocellular carcinoma (If checked, go to 16) ☐

Hepatobiliary carcinoma, including intrahepatic and extrahepatic cholangiocarcinoma (If checked, go to 16) ☐

Breast cancer (If checked, go to 16) ☐

Salivary gland tumors (If checked, go to 16) ☐

Esophageal and esophagogastric junction cancers (If checked, go to 16) ☐

Gastric cancer (If checked, go to 16) ☐

Soft tissue sarcoma of the extremity/body wall, head/neck, retroperitoneal/intra-abdominal sarcoma (If checked, go to 16) ☐

Ampullary adenocarcinoma (If checked, go to 16) ☐

Vaginal cancer (If checked, go to 16) ☐

Other, please specify. (If checked, go to 17) ☐

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

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

Recurrent disease (If checked, go to 18) ☐

Persistent disease (If checked, go to 18) ☐

Progressive disease (If checked, go to 18) ☐

Unresectable disease (If checked, go to 18) ☐

Advanced disease (If checked, go to 18) ☐

Metastatic disease (If checked, go to 18) ☐

Other, please specify. (If checked, no further questions) ☐

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18. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.

Yes (If checked, go to 19) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19. Has the disease not responded to preoperative therapy? Y ☐ N ☐

20. Has the disease progressed on or following prior systemic treatment? Y ☐ N ☐

21. Does the patient have no satisfactory alternative treatment options? Y ☐ N ☐

22. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results of RET gene fusion.
    - Yes (If checked, go to 23) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

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

24. Does the patient have symptomatic disease? Y ☐ N ☐

25. Does the patient have relapsed or refractory disease? Y ☐ N ☐

26. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.
    - Yes (If checked, go to 27) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

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

28. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.
    - Yes (If checked, go to 29) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

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

30. Has the disease progressed on or following prior systemic treatment? Y ☐ N ☐

31. Does the patient have no satisfactory alternative treatment options? Y ☐ N ☐

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

33. Does the patient have a rearranged during transfection (RET) gene fusion? ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.
    - Yes (If checked, go to 34) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

34. Will the requested medication be used as neoadjuvant treatment? Y ☐ N ☐

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

- Resectable locoregional advanced disease (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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36. Has the disease progressed on or following prior systemic treatment? **Y** ☐ **N** ☐

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

- Unresectable disease (If checked, no further questions) ☐
- Resected gross residual (R2) disease (If checked, no further questions) ☐
- Metastatic disease (If checked, no further questions) ☐
- Other, please specify. (If checked, no further questions) ☐

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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