Rubraca

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Uterine leiomyosarcoma
   - ❑ Primary peritoneal cancer
   - ❑ Prostate cancer
   - ❑ Pancreatic Adenocarcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred products for your patient's health plan are Lynparza and Zejula. Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Lynparza ❑ Yes - Zejula ❑ No - Continue request for Rubraca
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes ❑ Yes ❑ No *If Yes, skip to #9*
6. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ❑ Yes ❑ No *No further questions.*
7. *If the diagnosis is prostate or pancreatic cancer,* does the patient have a documented inadequate response or intolerable adverse event to treatment with Lynparza? ***ACTION REQUIRED: If Yes, attach supporting chart notes.*** *If Yes, or No, skip to #9* ❑ Yes ❑ No ❑ N/A diagnosis is NOT prostate or pancreatic cancer, *continue to #8*
8. Does the patient have a documented inadequate response or intolerable adverse event to treatment with both of the preferred products (Lynparza and Zejula)? ❑ Yes ❑ No
9. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No *If No, skip to #11*
10. Is there evidence of disease progression or unacceptable toxicity while on the current regimen? ❑ Yes ❑ No *No further questions.*
11. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Epithelial Ovarian Cancer, Primary Peritoneal Cancer, Fallopian Tube Cancer

12. Does the patient have germline or somatic BRCA-mutated disease? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA mutation status.*** ❑ Yes ❑ No ❑ Unknown

13. Will the requested drug be used as maintenance therapy? ❑ Yes ❑ No

14. What is the clinical setting in which the requested drug will be used?
    ❑ Recurrent disease
    ❑ Advanced (stage II-IV) disease, *skip to #16*
    ❑ Other: _____

15. Is the patient in a complete or partial response to platinum based chemotherapy?
    ❑ Yes ❑ No *No further questions*.

16. Is the patient in a complete or partial response to primary therapy? ❑ Yes ❑ No

Section B: Prostate Cancer

17. What clinical setting will the requested drug be used?
    ❑ Metastatic disease
    ❑ Other _____

18. Is the disease castration-resistant? ❑ Yes ❑ No

19. Does the tumor have a deleterious BRCA mutation (germline, somatic, or both)? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA mutation status.*** ❑ Yes ❑ No ❑ Unknown

20. Has the patient been treated with androgen receptor-directed therapy? ❑ Yes ❑ No

21. Has the patient been treated with a taxane-based chemotherapy? *If Yes, skip to #23* ❑ Yes ❑ No

22. Is the patient unfit for chemotherapy? ❑ Yes ❑ No

23. Will the patient receive concurrent therapy with a gonadotropin-releasing hormone (GnRH) analog?
    ❑ Yes ❑ No

24. Has the patient had a bilateral orchiectomy? ❑ Yes ❑ No

Section C: Uterine Leiomyosarcoma

25. Does the patient have BRCA2-altered uterine leiomyosarcoma? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA2 mutation status.*** ❑ Yes ❑ No ❑ Unknown

26. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment
    ❑ Subsequent treatment

27. What is the clinical setting in which the requested drug will be used?
    ❑ Advanced disease
    ❑ Recurrent disease
    ❑ Metastatic disease
    ❑ Inoperable disease
    ❑ Other _____

Section D: Pancreatic Adenocarcinoma

28. What is the clinical setting in which the requested drug will be used?
    ❑ Metastatic disease
    ❑ Other _____

29. Does the tumor have a BRCA mutation (germline or somatic) or a PALB2-mutation?

ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA or PALB2 mutation status.

- ❑ Yes - BRCA mutation (germline or somatic)
- ❑ Yes - PALB2 mutation
- ❑ Unknown

30. Has the patient already received a platinum-based chemotherapy (e.g., cisplatin, carboplatin) for at least 16 weeks? ❑ Yes ❑ No

31. Has the disease progressed during treatment with platinum-based chemotherapy (e.g., cisplatin, carboplatin)? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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