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 diagnosis?
   - Breast cancer (If checked, go to 2) ☐
   - Prostate cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

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

4. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

5. What is the diagnosis?
   - Breast cancer (If checked, go to 6) ☐
   - Prostate cancer (If checked, go to 9) ☐

6. What is the clinical setting in which the requested medication will be used?
   - No response to preoperative systemic therapy (If checked, go to 7) ☐
   - Locally advanced disease (If checked, go to 7) ☐
   - Recurrent disease (If checked, go to 7) ☐
   - Metastatic disease (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

7. Does the patient have a deleterious or suspected deleterious germline BRCA mutation?
   ACTION REQUIRED: If Yes, please attach BRCA mutation test results or chart note(s).
   - 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 medication be given as a single agent? **Y** ☐ **N** ☐

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

   Metastatic disease (If checked, go to 10) ☐

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

   _____

10. Is the disease castration-resistant? **Y** ☐ **N** ☐

11. Does the patient have homologous recombination repair (HRR)-gene mutation which includes ATM, ATR, BRCA1, BRCA2, CDK12, CHEK2, FANCA, MLH1, MRE11A, NBN, PALB2, or RAD51C? ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming HRR mutation status.

   Yes (If checked, go to 12) ☐

   No (If checked, no further questions) ☐

   Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

12. Has the patient had treatment in the setting of castration-resistant prostate cancer? **Y** ☐ **N** ☐

13. Will the requested medication be used in combination with enzalutatmide (Xtandi)? **Y** ☐ **N** ☐

14. Has the patient had a bilateral orchiectomy? **Y** ☐ **N** ☐

15. Will the patient receive concurrent therapy with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., goserelin, leuprolide) or antagonist (e.g., degarelix, relugolix)? **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