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:** 10/11/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
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?
   - Acute myeloid leukemia (AML) (If checked, go to 2) ☐
   - Cholangiocarcinoma (If checked, go to 11) ☐
   - Chondrosarcoma (If checked, go to 17) ☐
   - Myelodysplastic syndromes (MDS) (If checked, go to 21) ☐
   - CNS cancers (If checked, go to 25) ☐
   - 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. Does patient's acute myeloid leukemia have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of isocitrate dehydrogenase-1 (IDH1) mutation.
   - Yes (If checked, go to 5) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

5. What is the clinical setting in which the requested medication will be used?
   - Newly diagnosed acute myeloid leukemia (If checked, go to 6) ☐
   - Post induction therapy for acute myeloid leukemia (If checked, go to 9) ☐
   - Relapsed acute myeloid leukemia (If checked, no further questions) ☐
   - Refractory acute myeloid leukemia (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

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6. What is the patient's age?
   - Less than 75 years of age (If checked, go to 7) ☐
   - 75 years of age or older (If checked, go to 8) ☐

7. Is the patient a candidate for intensive induction therapy? **Y** ☐ **N** ☐

8. Will the requested medication be used in any of the following regimens?
   - Single agent (If checked, no further questions) ☐
   - In combination with azacitidine (Vidaza) (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

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9. Has the patient experienced a response to therapy with the requested medication? **Y** ☐ **N** ☐

10. Will the requested medication be used in any of the following regimens?
    - Single agent (If checked, no further questions) ☐
    - In combination with azacitidine (Vidaza) (If checked, no further questions) ☐
    - Other, please specify. (If checked, no further questions) ☐

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11. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

13. Does patient's cholangiocarcinoma have an isocitrate dehydrogenase-1 (IDH1) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of isocitrate dehydrogenase-1 (IDH1) mutation.
    - Yes (If checked, go to 14) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

14. What is the clinical setting in which the requested medication will be used?
    - Unresectable disease (If checked, go to 15) ☐
    - Locally advanced disease (If checked, go to 15) ☐
    - Metastatic disease (If checked, go to 15) ☐
    - Resected gross residual (R2) disease (If checked, go to 15) ☐
    - Other, please specify. (If checked, no further questions) ☐

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15. What is the place in therapy in which the requested medication will be used?
    - As first-line treatment (If checked, no further questions) ☐
    - As subsequent treatment (If checked, go to 16) ☐
    - Other, please specify. (If checked, no further questions) ☐

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

17. Is the patient currently being treated with the requested medication? **Y** ☐ **N** ☐

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

19. Does the patient's chondrosarcoma have a susceptible isocitrate dehydrogenase-1 (IDH-1) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of isocitrate dehydrogenase-1 (IDH1) mutation.

- ☐ Yes (If checked, go to 20)
- ☐ No (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

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

- ☐ Conventional (grades 1-3) chondrosarcoma (If checked, no further questions)
- ☐ Dedifferentiated chondrosarcoma (If checked, no further questions)
- ☐ Other, please specify. (If checked, no further questions)

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21. Is the patient currently being treated with the requested medication? **Y** ☐ **N** ☐

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

23. Does patient's myelodysplastic syndrome have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results of isocitrate dehydrogenase-1 (IDH1) mutation.

- ☐ Yes (If checked, go to 24)
- ☐ No (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

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

- ☐ Relapsed disease (If checked, no further questions)
- ☐ Refractory disease (If checked, no further questions)
- ☐ Other, please specify. (If checked, no further questions)

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25. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

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

27. Does the patient have isocitrate dehydrogenase-1 (IDH1) mutant astrocytoma (WHO Grade 2) or isocitrate dehydrogenase-1 (IDH1) mutant oligodendroglioma (WHO Grade 2 or 3)? ACTION REQUIRED: If Yes, attach chart note(s) or test results of IDH1 mutation status

- ☐ Yes, IDH1 mutant astrocytoma (WHO Grade 2) (If checked, go to 28)
- ☐ Yes, IDH1 mutant oligodendroglioma (WHO Grade 2 or 3) (If checked, go to 28)
- ☐ No (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

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

- ☐ Recurrent disease (If checked, go to 29)
- ☐ Progressive disease (If checked, go to 29)
- ☐ Other, please specify. (If checked, no further questions)

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

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

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