PA Request Criteria

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202264

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:** 8/12/2024
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 medication? **Y** ☐ **N** ☐

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

4. What is the tumor's hormone receptor (HR) status? ACTION REQUIRED: Please attach chart note(s) or test results of hormone receptor (HR) status.
   - HR positive (If checked, go to 5) ☐
   - HR negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

5. What is the tumor's human epidermal growth factor receptor-2 (HER2) status? ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor-2 (HER2) status.
   - HER2 positive (If checked, no further questions) ☐
   - HER2 negative (If checked, go to 6) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

6. Does the patient have phosphatidylinositol 3-kinase/serine/threonine kinase AKT1/phosphatase and tensin homolog (PIK3CA/AKT1/PTEN)-mutated disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results of PIK3CA, AKT1 or PTEN mutation status.
   - Yes (If checked, go to 7) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

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

- Locally advanced disease (If checked, go to 8) ☐
- Recurrent disease (If checked, go to 8) ☐
- Metastatic disease (If checked, go to 8) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

8. Will the requested medication be used in combination with fulvestrant (Faslodex)? **Y** ☐ **N** ☐

9. Which of the following applies to the patient's disease?

- The patient had disease progression while on or after receiving at least one endocrine-based regimen, including a cyclin-dependent kinase 4 and 6 (CDK4/6) inhibitor (e.g., palbociclib [Ibrance], ribociclib [Kisqali], abemaciclib [Verzenio]), in the metastatic setting (If checked, no further questions) ☐
- The patient had disease recurrence while on or within 12 months of completing adjuvant therapy with an endocrine-based regimen (If checked, no further questions) ☐
- Other, please specify. (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.

_____

Prescriber (Or Authorized) Signature and Date

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