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 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 patient's diagnosis?
   - Appendiceal adenocarcinoma (If checked, go to 2) ☐
   - Appendiceal carcinoma (If checked, go to 2) ☐
   - Breast cancer (If checked, go to 2) ☐
   - Colon cancer (If checked, go to 2) ☐
   - Biliary tract cancers (including gallbladder cancer, intrahepatic and extrahepatic cholangiocarcinoma) (If checked, go to 2) ☐
   - Rectal cancer (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

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

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

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

5. What is the diagnosis?
   - Appendiceal adenocarcinoma (If checked, go to 11) ☐
   - Appendiceal carcinoma (If checked, go to 11) ☐
   - Breast cancer (If checked, go to 6) ☐
   - Colon cancer (If checked, go to 11) ☐
   - Biliary tract cancers (including gallbladder cancer, intrahepatic and extrahepatic cholangiocarcinoma) (If checked, go to 17) ☐
   - Rectal cancer (If checked, go to 11) ☐

6. What is the clinical setting in which the requested medication will be used?
   - Initial therapy (If checked, go to 7) ☐

Subsequent therapy (If checked, go to 8) ☐

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

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7. Does the patient have small asymptomatic brain metastases? **Y** ☐ **N** ☐

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

Recurrent unresectable disease (If checked, go to 9) ☐

Advanced unresectable disease (If checked, go to 9) ☐

Metastatic disease, including limited or extensive brain metastases (If checked, go to 9) ☐

No response to preoperative systemic therapy (If checked, go to 9) ☐

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

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9. What is the patient'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, go to 10) ☐

HER2-Negative (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. Will the requested drug be used in combination with trastuzumab (Herceptin) and capecitabine (Xeloda)? **Y** ☐ **N** ☐

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

Unresectable disease (If checked, go to 12) ☐

Inoperable disease (If checked, go to 12) ☐

Advanced disease (If checked, go to 12) ☐

Metastatic disease (If checked, go to 12) ☐

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

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12. What is the patient'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, go to 13) ☐

HER2-Negative (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

13. Is the disease negative (wild-type) for RAS (KRAS and NRAS) and BRAF mutations? ACTION REQUIRED: Please attach chart note(s) or test results confirming negative (wild-type) RAS (KRAS and NRAS) and BRAF mutation status.

Yes (If checked, go to 14) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

14. Will the requested medication be used in combination with trastuzumab (Herceptin)? **Y** ☐ **N** ☐

15. Is intensive therapy appropriate for the patient? **Y** ☐ **N** ☐

16. Has the patient experienced disease progression? **Y** ☐ **N** ☐

17. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

- HER2 positive (If checked, go to 18) ☐
- HER2 negative (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

18. What is the clinical setting in which the requested drug will be used?

- Locally advanced disease (If checked, go to 19) ☐
- Unresectable disease (If checked, go to 19) ☐
- Resected gross residual (R2) (If checked, go to 19) ☐
- Metastatic disease (If checked, go to 19) ☐
- Other, please specify. (If checked, no further questions) ☐

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19. What is the place in therapy in which the requested drug will be used?

- First-line treatment (If checked, no further questions) ☐
- Subsequent treatment (If checked, go to 20) ☐

20. Will the requested drug be used in combination with trastuzumab (Herceptin)? **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.

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Prescriber (Or Authorized) Signature and Date