PA Request Criteria

00-000000000

259026

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:** 10/9/2026
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 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 drug? **Y** ☐ **N** ☐

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

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

5. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: If Positive, attach chart note(s) or test results of hormone receptor (HR) status.
   - HR-Positive (If checked, go to 6) ☐
   - HR-Negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

6. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ACTION REQUIRED: If Negative, 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 7) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

7. Is the tumor estrogen receptor 1 (ESR1) mutated? ACTION REQUIRED: If Yes, attach chart note(s) or test results of estrogen receptor 1 (ESR1) mutation status.
   - Yes (If checked, go to 8) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

- Recurrent unresectable disease (If checked, go to 9) ☐
- Advanced disease (If checked, go to 9) ☐
- Metastatic disease (If checked, go to 9) ☐
- The patient had no response to preoperative systemic therapy (If checked, go to 9) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

9. Has the patient received at least one prior line of endocrine therapy plus a cyclin-dependent kinase 4 and 6 (CDK4/6) inhibitor (e.g., abemaciclib [Verzenio], palbociclib [Ibrance], ribociclib [Kisqali])? **Y** ☐ **N** ☐

10. Is the patient postmenopausal? **Y** ☐ **N** ☐

11. Is hormone suppression being achieved through surgery, irradiation, or concomitant use with a gonadotropin-releasing hormone agonist (GnRH) (e.g., leuprolide [Lupron])? **Y** ☐ **N** ☐

12. Will the requested drug be used as a single agent? **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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.