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:** 7/18/2024
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?
   - Breast cancer (If checked, go to 2) ☐
   - Endometrial carcinoma (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. What is the clinical setting in which the requested medication will be used?
   - Early disease (If checked, go to 10) ☐
   - Recurrent disease (If checked, go to 3) ☐
   - Advanced disease (If checked, go to 3) ☐
   - Metastatic disease (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

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

5. What is the diagnosis?
   - Breast cancer (If checked, go to 6) ☐
   - Endometrial carcinoma (If checked, go to 19) ☐

6. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: If HR positive, attach chart note(s) or test results of hormone receptor (HR) status.
   - HR-positive (If checked, go to 7) ☐
   - HR-negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

7. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ACTION REQUIRED: If HER2 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 8)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

8. Will the requested medication be given in any of the following regimens?

- ☐ As monotherapy (If checked, go to 9)
- ☐ In combination with fulvestrant (If checked, no further questions)
- ☐ In combination with an aromatase inhibitor (e.g., letrozole, anastrozole, exemestane) (If checked, no further questions)
- ☐ Other, please specify. (If checked, no further questions)

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9. Did the patient experience disease progression following endocrine therapy and prior chemotherapy in the metastatic setting? **Y** ☐ **N** ☐

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

11. Is there evidence of unacceptable toxicity or disease recurrence on the current regimen? **Y** ☐ **N** ☐

12. How many months has the patient received therapy with the requested medication?

- ☐ 12 months or less (If checked, no further questions)
- ☐ 13 months (If checked, no further questions)
- ☐ 14 months (If checked, no further questions)
- ☐ 15 months (If checked, no further questions)
- ☐ 16 months (If checked, no further questions)
- ☐ 17 months (If checked, no further questions)
- ☐ 18 months (If checked, no further questions)
- ☐ 19 months (If checked, no further questions)
- ☐ 20 months (If checked, no further questions)
- ☐ 21 months (If checked, no further questions)
- ☐ 22 months (If checked, no further questions)
- ☐ 23 months (If checked, no further questions)
- ☐ 24 months and greater (If checked, no further questions)

13. What is the patient's hormone receptor (HR) status? ACTION REQUIRED: If HR positive, attach chart note(s) or test results of hormone receptor (HR) status.

- ☐ HR-positive (If checked, go to 14)
- ☐ HR-negative (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

14. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ACTION REQUIRED: If HER2 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 15)

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

15. Will the requested medication be used as adjuvant treatment? **Y** ☐ **N** ☐

16. Will the requested medication be given in combination with endocrine therapy (tamoxifen or an aromatase inhibitor [e.g., letrozole, anastrozole, exemestane])?

Yes (If checked, go to 17) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

17. Does the patient have node positive disease?

Yes, four or more positive lymph nodes (If checked, no further questions) ☐

Yes, one to three positive lymph nodes (If checked, go to 18) ☐

No (If checked, no further questions) ☐

18. Does the patient have any of the following?

Grade 3 disease (If checked, no further questions) ☐

Tumor size of 5 cm or greater (If checked, no further questions) ☐

None of the above (If checked, no further questions) ☐

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

Advanced disease (If checked, go to 20) ☐

Recurrent disease (If checked, go to 20) ☐

Metastatic disease (If checked, go to 20) ☐

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

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20. What is the patient's estrogen receptor tumor status? ACTION REQUIRED: If Positive, attach chart note(s) or test results confirming positive estrogen receptor tumor status.

Positive (If checked, go to 21) ☐

Negative (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

21. Will the requested medication be used in combination with letrozole? **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