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:** 9/9/2024
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 diagnosis?
   - Advanced renal cell carcinoma (If checked, go to 2) ☐
   - von Hippel-Lindau associated renal cell carcinoma (If checked, go to 2) ☐
   - von Hippel-Lindau associated central nervous system (CNS) hemangioblastomas (If checked, go to 2) ☐
   - von Hippel-Lindau associated pancreatic neuroendocrine tumors (pNET) (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 diagnosis?
   - Renal cell carcinoma (If checked, go to 5) ☐
   - von Hippel-Lindau associated central nervous system (CNS) hemangioblastomas (If checked, go to 6) ☐
   - von Hippel-Lindau associated pancreatic neuroendocrine tumors (pNET) (If checked, go to 7) ☐
5. Which of the following applies to the patient's disease?
   - von Hippel-Lindau associated renal cell carcinoma (If checked, go to 6) ☐
   - Advanced disease (If checked, go to 9) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
7. Does the patient require immediate surgery? **Y** ☐ **N** ☐

8. Has the diagnosis been confirmed by genetic testing? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming germline VHL alteration.

   Yes (If checked, no further questions) ☐

   No (If checked, no further questions) ☐

   Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

9. Has the patient been previously treated with a PD-1/PD-L1 inhibitor (e.g., nivolumab [Opdivo], pembrolizumab [Keytruda])? **Y** ☐ **N** ☐

10. Has the patient been previously treated with a VEGF-TKI (e.g., axitinib [Inlyta], cabozantinib [Cabometyx], lenvatinib [Lenvima])? **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