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:** 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?
   - Castration-resistant prostate cancer (CRPC) (If checked, go to 2) ☐
   - Metastatic castration-sensitive prostate cancer (mCSPC) (If checked, go to 2) ☐
   - Non-metastatic castration-sensitive prostate cancer (nmCSPC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____
2. Will the requested drug be used in combination with either of the following classes of medication: a) Second-generation oral anti-androgen (e.g., apalutamide [Erleada]), b) Oral androgen metabolism inhibitor (e.g., abiraterone acetate Zytiga)? **Y** ☐ **N** ☐
3. Is the patient currently receiving therapy with the requested drug? **Y** ☐ **N** ☐
4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
5. What is the patient's diagnosis?
   - Castration-resistant prostate cancer (CRPC) (If checked, go to 6) ☐
   - Metastatic castration-sensitive prostate cancer (mCSPC) (If checked, go to 6) ☐
   - Non-metastatic castration-sensitive prostate cancer (nmCSPC) (If checked, go to 8) ☐
6. Has the patient had a bilateral orchiectomy? **Y** ☐ **N** ☐
7. Will the requested drug be used in combination with a GnRH agonist or degarelix? **Y** ☐ **N** ☐
8. Does the disease have a biochemical recurrence at high risk for metastasis? **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

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