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 diagnosis?
   - Epithelial ovarian, fallopian tube, or primary peritoneal cancer (If checked, go to 2) ☐
   - Uterine leiomyosarcoma (If checked, go to 2) ☐
   - Prostate cancer (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 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 diagnosis?
   - Epithelial ovarian, fallopian tube, or primary peritoneal cancer (If checked, go to 6) ☐
   - Uterine leiomyosarcoma (If checked, go to 12) ☐
   - Prostate cancer (If checked, go to 16) ☐

6. Is the requested medication being used as maintenance treatment? **Y** ☐ **N** ☐

7. Is the patient in a complete or partial response to platinum-based (e.g., cisplatin, carboplatin) chemotherapy? **Y** ☐ **N** ☐

8. What clinical setting will the requested medication be used?
   - Advanced (Stage II-IV) disease (If checked, go to 9) ☐
   - Recurrent disease (If checked, go to 10) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

9. What is the requested regimen?

Single agent (If checked, no further questions) ☐

In combination with bevacizumab (Avastin) (If checked, no further questions) ☐

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

_____

10. What is the requested regimen?

Single agent (If checked, go to 11) ☐

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

_____

11. Does the patient have a deleterious or suspected deleterious germline BRCA mutation? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA mutation status.

Yes (If checked, no further questions) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

12. Does the patient have BRCA2-altered uterine leiomyosarcoma? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRCA2 mutation status.

Yes (If checked, go to 13) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

13. What is the place in therapy in which the requested medication will be used?

First-line treatment (If checked, no further questions) ☐

Subsequent treatment (If checked, go to 14) ☐

14. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

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

Advanced disease (If checked, no further questions) ☐

Recurrent disease (If checked, no further questions) ☐

Metastatic disease (If checked, no further questions) ☐

Inoperable disease (If checked, no further questions) ☐

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

_____

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

Metastatic disease (If checked, go to 17) ☐

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

_____

17. Is the disease castration-resistant? **Y** ☐ **N** ☐

18. Does the disease have BRCA1 or BRCA2 mutation? ACTION REQURED: If Yes, attach chart note(s) or test results confirming BRCA mutation status.

Yes (If checked, go to 19) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19.	Has the patient had a bilateral orchiectomy?	**Y** ☐	**N** ☐
20.	Will the requested medication be used in combination with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., goserelin, leuprolide) or antagonist (e.g., degarelix, relugolix)?	**Y** ☐	**N** ☐
21.	Will the requested medication be used in combination with abiraterone and concurrent steroids (prednisone or methylprednisolone)?	**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