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?
   - Non-small cell lung cancer (including brain metastases from non-small cell lung cancer) (If checked, go to 2) ☐
   - Inflammatory myofibroblastic tumor (IMT) (If checked, go to 7) ☐
   - Erdheim-Chester Disease (ECD) (If checked, go to 13) ☐
   - Anaplastic Large Cell Lymphoma (ALCL) (If checked, go to 18) ☐
   - Other, please specify. (If checked, no further questions) ☐

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

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

4. Which of the following genetic alterations apply to the patient? ACTION REQUIRED: If any applies, attach chart note(s) or test results confirming genetic alterations.
   - Anaplastic lymphoma kinase (ALK)-positive NSCLC (including brain metastases from NSCLC) (If checked, go to 5) ☐
   - Repressor of silencing (ROS)1-positive NSCLC (If checked, go to 5) ☐
   - None of the above or unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

5. What is the clinical setting in which the requested medication will be used?
   - Recurrent disease (If checked, go to 6) ☐
   - Advanced disease (If checked, go to 6) ☐
   - Metastatic disease (If checked, go to 6) ☐
   - Other, please specify. (If checked, no further questions) ☐

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

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

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

9. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming positive ALK.
   - Yes (If checked, go to 10) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

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

11. Which type of sarcoma applies to the patient's disease?
   - Soft tissue sarcoma (If checked, no further questions) ☐
   - Uterine sarcoma (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

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12. 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) ☐

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

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

15. What is the clinical setting in which the requested medication will be used?
   - Symptomatic disease (If checked, go to 16) ☐
   - Relapsed/refractory disease (If checked, go to 16) ☐
   - Other, please specify. (If checked, no further questions) ☐

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16. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming positive ALK.
   - Yes (If checked, go to 17) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

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

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

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

20. Is the tumor anaplastic lymphoma kinase (ALK)-positive? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming positive ALK.

Yes (If checked, go to 21) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

Initial palliative therapy (If checked, go to 22) ☐

Relapsed/refractory disease (If checked, go to 22) ☐

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

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22. Will the requested medication 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.

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Prescriber (Or Authorized) Signature and Date