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:** 5/29/2025
**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 patient's diagnosis?
   - Prostate cancer (If checked, go to 2) ☐
   - Salivary gland tumor (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the requested medication be used in combination with either of the following classes of medication? A) Second-generation oral anti-androgen (e.g., apalutamide [Erleada]) or B) Oral androgen metabolism inhibitor (e.g., fine-particle abiraterone acetate [Yonsa]) **Y** ☐ **N** ☐

3. Is the patient currently receiving therapy with the requested medication? **Y** ☐ **N** ☐

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

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

6. What is the patient's diagnosis?
   - Prostate cancer (If checked, go to 7) ☐
   - Salivary gland tumor (If checked, go to 10) ☐

7. What is the clinical setting in which the requested medication will be used?
   - Metastatic disease (If checked, go to 8) ☐
   - Non-metastatic node positive disease (If checked, go to 8) ☐
   - Non-metastatic high-risk disease (If checked, go to 8) ☐
   - Non-metastatic very-high-risk disease (If checked, go to 8) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

8. Has the patient had a bilateral orchiectomy? **Y** ☐ **N** ☐

9. Will the requested medication be used with a luteinizing hormone-releasing hormone (LHRH) agonist (e.g., goserelin, leuprolide) or antagonist (e.g., degarelix, relugolix)? **Y** ☐ **N** ☐

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

- Recurrent disease (If checked, go to 11) ☐
- Unresectable disease (If checked, go to 11) ☐
- Metastatic disease (If checked, go to 11) ☐
- Other, please specify. (If checked, no further questions) ☐

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11. Will the requested medication be used in combination with prednisone? **Y** ☐ **N** ☐

12. Is the tumor androgen receptor positive? **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**