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:** 9/6/2024
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?
   - Non-small cell lung cancer (including brain metastases from non-small cell lung cancer) (If checked, go to 3) ☐
   - Pancreatic cancer (If checked, go to 2) ☐
   - Chordoma (If checked, go to 2) ☐
   - Renal cell carcinoma (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 the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
5. Is the disease T790M negative? **Y** ☐ **N** ☐
6. Is there evidence of either unacceptable toxicity or disease progression while on the current regimen?
   - Yes, unacceptable toxicity (If checked, no further questions) ☐
   - Yes, disease progression (If checked, no further questions) ☐
   - No (If checked, no further questions) ☐
7. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
8. What is the patient's diagnosis?
   - Non-small cell lung cancer (including brain metastases from non-small cell lung cancer) (If checked, go to 9) ☐
   - Pancreatic cancer (If checked, go to 13) ☐
   - Chordoma (If checked, go to 15) ☐

Renal cell carcinoma (If checked, go to 17) ☐

9. What is the clinical setting in which the requested drug will be used?
   - Recurrent disease (If checked, go to 10) ☐
   - Advanced disease (If checked, go to 10) ☐
   - Metastatic disease (If checked, go to 10) ☐
   - Other, please specify. (If checked, no further questions) ☐

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10. Does the patient have sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results of EGFR mutation.
    - Yes (If checked, go to 11) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

11. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

12. Will the requested drug be used in combination with ramucirumab or bevacizumab? **Y** ☐ **N** ☐

13. What is the clinical setting in which the requested drug will be used?
    - Locally advanced disease (If checked, go to 14) ☐
    - Unresectable disease (If checked, go to 14) ☐
    - Recurrent disease (If checked, go to 14) ☐
    - Metastatic disease (If checked, go to 14) ☐
    - Other, please specify. (If checked, no further questions) ☐

    _____

14. Will the requested drug be used in combination with gemcitabine? **Y** ☐ **N** ☐

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

    _____

16. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

17. What is the clinical setting in which the requested drug will be used?
    - Relapsed disease (If checked, go to 18) ☐
    - Stage IV disease (If checked, go to 18) ☐
    - Other, please specify. (If checked, no further questions) ☐

    _____

18. Does the disease have non-clear cell histology? **Y** ☐ **N** ☐

19. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

20. Will the requested drug be used in combination with bevacizumab? **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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