PA Request Criteria

00-000000000

211030

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:** 7/17/2024
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?
   - Breast cancer (If checked, go to 2) ☐
   - Central nervous system (CNS) metastases from breast cancer (If checked, go to 2) ☐
   - Chordoma (If checked, go to 2) ☐
   - Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

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

4. What is the patient's diagnosis?
   - Breast cancer (If checked, go to 7) ☐
   - Central nervous system (CNS) metastases from breast cancer (If checked, go to 5) ☐
   - Chordoma (If checked, go to 12) ☐
   - Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (If checked, go to 15) ☐

5. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ACTION REQUIRED: If Positive, attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
   - HER2-positive (If checked, go to 6) ☐
   - HER2-negative (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

6. Will the requested medication be given in combination with capecitabine? **Y** ☐ **N** ☐

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

No response to preoperative systemic therapy (If checked, go to 8) ☐

Recurrent disease (If checked, go to 8) ☐

Advanced disease (If checked, go to 8) ☐

Metastatic disease (If checked, go to 8) ☐

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

_____

8. What is the patient's human epidermal growth factor 2 (HER2) status? ACTION REQUIRED: If HER2 positive, attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

HER2-positive (If checked, go to 9) ☐

HER2-negative (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

9. Does the patient have hormone receptor-positive disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results of hormone receptor status.

Yes (If checked, go to 10) ☐

No (If checked, go to 11) ☐

Unknown (If checked, go to 11) ☐

ACTION REQUIRED: Submit supporting documentation

10. Will the requested medication be given in any of the following regimens?

In combination with an aromatase inhibitor (e.g., letrozole, anastrazole, or exemestane) (If checked, no further questions) ☐

In combination with an aromatase inhibitor (e.g., letrozole, anastrazole, or exemestane) with trastuzumab (Herceptin) (If checked, no further questions) ☐

None of the above (If checked, go to 11) ☐

11. Will the requested medication be given in combination with capecitabine (Xeloda) or trastuzumab (Herceptin)? **Y** ☐ **N** ☐

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

Recurrent disease (If checked, go to 13) ☐

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

_____

13. What is the patient's epidermal growth factor receptor (EGFR) status? ACTION REQUIRED: If EGFR positive, attach chart note(s) or test results of epidermal growth factor receptor (EGFR) status.

EGFR-positive (If checked, go to 14) ☐

EGFR-negative (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

15. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ACTION REQUIRED: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

HER2-amplified (If checked, go to 16) ☐

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

_____

ACTION REQUIRED: Submit supporting documentation

16. Does the patient have RAS and BRAF wild-type disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results RAS and BRAF mutation status.

- 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 in combination with trastuzumab (Herceptin)? **Y** ☐ **N** ☐

18. Is the patient appropriate for intensive therapy? **Y** ☐ **N** ☐

19. Will the requested medication be used as subsequent therapy for progression of advanced or metastatic disease? **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