



## Abraxane

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ kg

*Patient Height:* \_\_\_\_\_ cm

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Abraxane SGM 1669-A - 06.2022.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

**Criteria Questions:**

1. What is the diagnosis?
  - Pancreatic adenocarcinoma
  - Breast cancer
  - Non-small cell lung cancer (NSCLC)
  - Cutaneous melanoma
  - Epithelial ovarian cancer
  - Fallopian tube cancer
  - Primary peritoneal cancer
  - Kaposi sarcoma
  - Endometrial carcinoma
  - Intrahepatic cholangiocarcinoma
  - Extrahepatic cholangiocarcinoma
  - Gallbladder cancer
  - Uveal melanoma
  - Small bowel adenocarcinoma, including advanced ampullary cancer
  - Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is this a request for continuation of therapy with the requested drug?  Yes  No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?  
 Yes  No *No further questions*
5. How is the patient's disease classified?

<input type="checkbox"/> Unresectable disease	<input type="checkbox"/> Metastatic disease	<input type="checkbox"/> Persistent disease
<input type="checkbox"/> Recurrent disease	<input type="checkbox"/> Advanced disease	<input type="checkbox"/> Distant metastatic disease
<input type="checkbox"/> Other _____		
6. Will the requested drug be used as any of the following? **Indicate ALL that apply.**
  - As single-agent therapy
  - In combination with gemcitabine
  - As single-agent as second-line or subsequent therapy
  - In combination with carboplatin as second-line or subsequent therapy
  - None of the above
7. Will the requested drug be used as a paclitaxel or docetaxel substitute due to hypersensitivity reactions or contraindication to standard hypersensitivity premedications?
  - Yes - Due to hypersensitivity reactions
  - Yes - Contraindication to standard hypersensitivity premedications
  - No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

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