Alimta, Pemfexy, pemetrexed

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** _____________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

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*

<u>Clinical Criteria Questions:</u>

1. What is the diagnosis?
   ❑ Non-small cell lung cancer (NSCLC)
   ❑ Thymoma or thymic carcinoma
   ❑ Bladder cancer (transitional cell urothelium cancer)
   ❑ Primary peritoneal cancer
   ❑ Malignant pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma
   ❑ Epithelial ovarian cancer (including carcinosarcoma [malignant mixed Müllerian tumor], clear cell carcinoma of the ovary, grade 1 endometrioid carcinoma, low-grade serous carcinoma/ovarian borderline epithelial tumor [low malignant potential] or mucinous carcinoma of the ovary)
   ❑ Other ____________________________________
   ❑ Fallopian tube cancer
   ❑ Primary central nervous system (CNS) lymphoma
   ❑ Cervical cancer

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. Alimta SGM – 02/2023.

2. What is the ICD-10 code? ________________

3. Is this a request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Non-Small Cell Lung Cancer (NSCLC)

5. What is the histology for the disease?
   ❑ Non-squamous histology
   ❑ Squamous histology

Section B: Malignant pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma

6. Will the requested medication be given in any of the following regimens?
   ❑ As a single agent
   ❑ In combination with cisplatin or carboplatin
   ❑ In combination with bevacizumab and either cisplatin or carboplatin
   ❑ None of the above

Section C: Thymoma or Thymic Carcinoma

7. Will the requested medication be given as a single agent? ❑ Yes ❑ No

Section D: Bladder Cancer (Transitional Cell Urothelium Cancer)

8. What is the clinical setting in which the requested medication will be used?
   ❑ Locally advanced disease
   ❑ Relapsed disease
   ❑ Metastatic disease
   ❑ Other ____

9. Will the requested medication be given as second-line treatment? ❑ Yes ❑ No

Section E: Epithelial Ovarian Cancer, Fallopian Tube Cancer, Primary Peritoneal Cancer, Primary Central Nervous System (CNS) Lymphoma

10. Will the requested medication be given as single agent? ❑ Yes ❑ No
    If diagnosis is Primary Central Nervous System (CNS) lymphoma, no further questions.

11. What is the clinical setting in which the requested medication will be used?
    ❑ Persistent disease
    ❑ Recurrent disease
    ❑ Other

Section F: Cervical Cancer

12. What is the clinical setting in which the requested medication will be used?
    ❑ Persistent disease
    ❑ Recurrent disease
    ❑ Other

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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