{{PANUMCODE}}

Balversa

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: ________________________________, NPI#: ___________________________
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Urothelial carcinoma - Bladder cancer
   ❑ Urothelial carcinoma - Primary carcinoma of the urethra
   ❑ Urothelial carcinoma - Upper genitourinary tract tumors
   ❑ Urothelial carcinoma - Urothelial carcinoma of the prostate
   ❑ Other ____
2. What is the ICD-10 code? ________________
3. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving therapy with the requested medication? ❑ Yes ❑ No *No further questions*
5. Will the requested medication be used as a single agent? ❑ Yes ❑ No
6. What is the place in therapy in which the requested drug will be used?
   ❑ First-line treatment
   ❑ Subsequent treatment
7. Does the patient have a susceptible fibroblast growth factor receptor (FGFR)3 or FGFR2 genetic alterations? ***ACTION REQUIRED: If Yes, attach laboratory test results.*** ❑ Yes ❑ No ❑ Unknown
9. What is the clinical setting in which the requested drug will be used?
   ❑ Locally advanced disease
   ❑ Metastatic disease
   ❑ Recurrent disease
   ❑ Stage II disease
   ❑ Other ____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

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

Urothelial Carcinoma - Bladder Cancer

10. Will the drug be used for either of the following?
    - ❑ Yes - Metastatic or local recurrence post-cystectomy
    - ❑ Yes - Muscle invasive local recurrence or persistent disease in a preserved bladder
    - ❑ No

11. *For Stage II disease only,* is the tumor present following reassessment of tumor status 2-3 months after primary treatment with bladder preserving concurrent chemoradiotherapy? ❑ Yes ❑ 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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