



Cosela

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 copy 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. Cosela SGM 4528-A - 07.2023.

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:

What is the ICD-10 code? _____

1. What is the diagnosis?

- Extensive-stage small cell lung cancer (ES-SCLC) (*If checked, go to 2*)
 Other, please specify. _____ (*If checked, go to 2*)

2. Is the patient 18 years of age or older?

- Yes, *Continue to 3*
 No, *Continue to 3*

3. Is the requested medication being used to decrease the incidence of chemotherapy-induced myelosuppression?

- Yes, *Continue to 4*
 No, *Continue to 4*

4. Please indicate which of the following chemotherapeutic regimens the patient is receiving:

- A platinum/etoposide-containing regimen (*If checked, go to 5*)
 A topotecan-containing regimen (*If checked, go to 5*)
 Other, please specify. _____ (*If checked, go to 5*)

5. Will the requested medication be given within 4 hours prior to the start of chemotherapy on each day chemotherapy is administered?

- Yes, *Continue to 6*
 No, *Continue to 6*

6. Will the requested medication be used with a granulocyte colony-stimulating factor (G-CSF) as primary prophylaxis during cycle 1?

- Yes, *Continue to 7*
 No, *Continue to 7*

7. Will the requested medication be used with an erythropoiesis-stimulating agent (ESA) as primary prophylaxis during cycle 1?

- Yes, *Continue to 8*
 No, *Continue to 8*

8. Is this request for initiation or continuation of therapy?

- Initiation of therapy (*If checked, no further questions*)
 Continuation of therapy (*If checked, no further questions*)

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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