

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



[[PANUMCODE]]

Ibrance

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.

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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}}

- What is the diagnosis?
 Breast cancer
 Liposarcoma (Soft tissue sarcoma)
 Other _____
- What is the ICD-10 code? _____
- Is the request for a continuation of therapy with the requested drug?
 Yes No *If No, skip to diagnosis section.*
- Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 Yes No *No further questions*

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

Section A: Breast Cancer

- Does the patient have recurrent, advanced or metastatic disease? Yes No
- What is the patient's hormone receptor (HR) status? **ACTION REQUIRED: Please attach documentation of hormone receptor (HR) status.**
 Positive
 Negative
 Unknown
- What is the human epidermal growth factor receptor 2 (HER2) status of the disease? **ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.**
 Positive
 Negative
 Unknown
- What is the prescribed regimen?
 Ibrance + aromatase inhibitor (eg, anastrozole [Arimidex], exemestane [Aromasin], letrozole [Femara])
 Ibrance + fulvestrant (Faslodex)
 Other _____

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

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Section B: Liposarcoma (Soft Tissue Sarcoma)

9. Does the patient have unresectable liposarcoma? Yes No

10. What is the histology?

Well-differentiated Dedifferentiated Myxoid Pleomorphic Other _____

11. Will Ibrance be used as a single agent? 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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