2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	**Phone** (10-15 **minutes** process time)	**Fax** (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Imfinzi

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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*

What is the ICD-10 code? _____

Site of Service Questions (SOS):

A. Indicate the site of service requested:

❑ On Campus Outpatient Hospital	❑ Off Campus Outpatient Hospital
❑ Home infusion, *skip to Criteria Questions*	❑ Physician office, *skip to Criteria Questions*
❑ Ambulatory surgical, *skip to Criteria Questions*	❑ Pharmacy, *skip to Criteria Questions.*

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

B. Is this request to continue previously established treatment with the requested medication?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested medication). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested medication for 6 months). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested medication for 7 months or greater – initial 6 months plus 45 days grace period).

C. Is the patient receiving provider administered combination chemotherapy? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

1.Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. What is the diagnosis?

❒ Non-small cell lung cancer (NSCLC), *Continue to #100*

❒ Extensive-stage small cell lung cancer (ES-SCLC), *Continue to #200*

❒ Hepatocellular carcinoma, *Continue to #300*

❒ Biliary tract cancer (gallbladder cancer, intrahepatic/extrahepatic cholangiocarcinoma), *Continue to #400*

❒ Cervical cancer, *Continue to #500*

❑ Ampullary adenocarcinoma, *Continue to #550*

❒ Other, *No Further Questions*

Non-small cell lung cancer (NSCLC)

100. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to #101*

❒ No, *Continue to #105*

Continuation Therapy

101. Which of the following applies to the patient's disease?
❒ Unresectable stage II or III disease, *Continue to #102*
❒ Recurrent disease, *Continue to #104*
❒ Advanced disease, *Continue to #104*
❒ Metastatic disease, *Continue to #104*

102. How many months of treatment has the patient received? (Please provide fill-in-the-blank)
❑ Less than 12 months, *Continue to #103*
❑ 12 months or longer, *Continue to #103*

103. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

104. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial Therapy

105. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *Continue to #107*

❒ Metastatic disease, *Continue to #107*

❒ Recurrent disease, *Continue to #107*

❒ Unresectable Stage II or Stage III disease, *Continue to #106*

❒ Other, *No Further Questions*

106. Has the disease progressed following concurrent platinum-based chemotherapy (e.g., cisplatin, carboplatin) and radiation therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

107. Will the requested medication be used in combination with tremelimumab-actl (Imjudo) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?

❒ Yes, *Continue to #108*

❒ No, *Continue to #108*

108. Is the tumor negative for epidermal growth factor receptor (EGFR) exon 19 deletion and L858R mutation and anaplastic lymphoma kinase (ALK) gene mutations? ***Action Required***: If 'Yes', please attach chart notes or test results of the absence of EGFR exon 19 deletion and L858R and ALK gene mutations, where applicable

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*
❒ Unknown, *Continue to #109*

109. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Extensive-stage small cell lung cancer (ES-SCLC)

200. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to #201*
❒ No, *Continue to #202*

Continuation Therapy

201. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial Therapy

202. Will the requested medication be used in combination with etoposide and either carboplatin or cisplatin followed by single agent maintenance?
❒ Yes, *Continue to #203*
❒ No, *Continue to #203*

203. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *No Further Questions*
❒ Subsequent treatment, *No Further Questions*

Hepatocellular carcinoma

300. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to #301*
❒ No, *Continue to #302*

Continuation Therapy

301. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initial Therapy

302.Will the requested medication be used in any of the following regimens?
❒ Single agent, *Continue to #303*
❒ In combination with tremelimumab-actl (Imjudo), *Continue to #305*
❒ Other, *No Further Questions*

303. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to #304*

❒ Subsequent treatment, *Continue to #304*

304. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *No Further Questions*

❒ Metastatic disease, *No Further Questions*

❒ Other, *No Further Questions*

305. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *No Further Questions*

❒ Other, *No Further Questions*

Biliary tract cancer (gallbladder cancer, intrahepatic/extrahepatic cholangiocarcinoma)

400. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to #401*

❒ No, *Continue to #402*

Continuation Therapy

401.Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial Therapy

402. Will the requested medication be used in combination with cisplatin and gemcitabine?

❒ Yes, *Continue to #403*

❒ No, *Continue to #403*

403. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease, *No Further Questions*

❒ Unresectable disease, *No Further Questions*

❒ Metastatic disease, *No Further Questions*

❒ Recurrent disease, *Continue to #404*

❒ Other, *No Further Questions*

404. Did the disease recur after surgery and adjuvant therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Cervical Cancer

500. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to #501*

❒ No, *Continue to #502*

Continuation Therapy

501.Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial Therapy

502. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?

❒ Yes, *Continue to #503*

❒ No, *No Further Questions*

503. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?

❒ Yes, *Continue to #504*

❒ No, *Continue to #504*

504. What is the clinical setting in which the requested medication will be used?

❒ Persistent disease, *No Further Questions*

❒ Recurrent disease, *No Further Questions*

❒ Metastatic disease, *No Further Questions*

❒ Other, *No Further Questions*

Ampullary Adenocarcinoma

550. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to #551*

❒ No, *Continue to #552*

Continuation Therapy

551. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial Therapy

552. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to #553*

❒ Metastatic disease, *Continue to #553*

❒ Other, *Continue to #553*

553. What is the disease type?

❒ Pancreatobiliary disease, *Continue to #554*

❒ Mixed type disease, *Continue to #554*

❒ Other, *Continue to #554*

554. Will the requested medication be used in combination with cisplatin and gemcitabine?

❒ Yes, *No Further Questions*

❒ No, *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)**

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