Infugem

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:** _____

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* ❑ *Inpatient Hospital* ❑ *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

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Pancreatic adenocarcinoma
   - ❑ Breast cancer
   - ❑ Heptobiliary and biliary tract cancer (including intrahepatic and extrahepatic choliangiocarcinoma, gallbladder cancer, and ampullary cancer)
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Primary peritoneal cancer
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Bladder cancer
   - ❑ Primary carcinoma of the urethra
   - ❑ Upper genitourinary tract tumor
   - ❑ Transitional cell carcinoma of the urinary tract
   - ❑ Urothelial carcinoma of the prostate
   - ❑ Non-urothelial cancer with variant histology
   - ❑ Urothelial cancer with variant histology
   - ❑ Small cell lung cancer (SCLC)
   - ❑ Soft tissue sarcoma (including extremity/superficial trunk, head/neck, retroperitoneal/intra-abdominal, angiosarcoma, and rhabdomyosarcoma)
   - ❑ Osteosarcoma
   - ❑ Ewing's sarcoma
   - ❑ Head or neck cancer (including very advanced head and neck cancer and cancer of the nasopharynx)
   - ❑ Classic Hodgkin lymphoma
   - ❑ Nodular lymphocyte-predominant Hodgkin lymphoma)
   - ❑ Kidney cancer
   - ❑ Malignant pleural mesothelioma
   - ❑ Occult primary tumor (cancer of unknown primary)
   - ❑ Testicular cancer
   - ❑ Thymoma or thymic carcinoma
   - ❑ Uterine neoplasm (including uterine sarcoma and uterine leiomyosarcoma)
   - ❑ AIDS-Related Kaposi Sarcoma
   - ❑ Primary cutaneous lymphoma (including mycosis fungoides/Sezary syndrome and primary cutaneous CD30+ T-Cell lymphoproliferative disorders)
   - ❑ T-cell lymphoma (including peripheral T-Cell lymphomas, adult T-Cell leukemia/lymphoma, hepatosplenic gamma-delta T-Cell lymphoma, and extranodal NKT/T-Cell lymphoma, nasal type
   - ❑ Gestational trophoblastic neoplasia
   - ❑ B-cell lymphoma (including follicular lymphoma [grade 1-2], histologic transformation of marginal zone lymphoma to diffuse large B-Cell lymphoma, mantle cell lymphoma, diffuse large B-Cell lymphoma, high-grade B-Cell lymphomas, Burkitt lymphoma, AIDS-Related B-Cell lymphomas, and post-transplant lymphoproliferative disorders)
   - ❑ Cervical cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. What is the clinical setting in which the requested medication will be used?
   - ❑ Advanced disease ❑ Metastatic disease ❑ Persistent disease
   - ❑ Progressive disease ❑ Recurrent disease ❑ Refractory disease
   - ❑ Relapsed disease ❑ None of the above

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

5. Has the patient experienced a clinical benefit or not experienced an unacceptable toxicity with the requested medication?
   ❑ Has experienced a clinical benefit
   ❑ Has not experienced an unacceptable toxicity
   ❑ None of the above

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

Section A: Gestational Trophoblastic Neoplasia

6. What type of disease does the patient have?
   ❑ Intermediate trophoblastic tumor (placental site trophoblastic tumor or epitheliod trophoblastic tumor)
   ❑ High-risk disease, *skip to #8*
   ❑ None of the above

7. Has the patient previously received treatment with a platinum/etoposide-containing regimen?
   ❑ Yes ❑ No *No further questions.*

8. Is the patient's disease resistant to treatment with methotrexate? ❑ Yes ❑ No

Section B: Cervical Cancer

9. Will the requested medication be used in combination with cisplatin as neoadjuvant therapy?
   ❑ 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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