

## Ixempra® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

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 866-249-6155.** If you have questions regarding the prior authorization, please contact CVS/caremark at **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 800-237-2767.

<b>Patient Name:</b>	<b>Date:</b>
<b>Patient's ID:</b>	<b>Patient's Date of Birth:</b>
<b>Physician's Name:</b>	
<b>Specialty:</b>	<b>NPI#:</b>
<b>Physician Office Telephone:</b>	<b>Physician Office Fax:</b>

**Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia and/or evidence-based practice guidelines.**

1. What drug is being prescribed?  Ixempra®  Other \_\_\_\_\_
2. What is the patient's diagnosis?  
 Breast cancer  
 Other \_\_\_\_\_
3. What is the ICD code? \_\_\_\_\_
4. Is the disease:  metastatic  locally advanced  recurrent
5. What is the treatment regimen?  
 In combination with capecitabine (Xeloda®)  
 Monotherapy  
 Other \_\_\_\_\_

**Complete the following section based on the patient's treatment regimen**

Section A: In combination with capecitabine (Xeloda®)

6. Has the patient tried but developed resistance to treatment with an anthracycline (e.g., doxorubicin [Adriamycin®], epirubicin [Ellence®], pegylated liposomal doxorubicin [Doxil®])?  Yes  No *If yes, skip to question 8*
7. Is further treatment with an anthracycline contraindicated?  Yes  No
8. Has the patient tried but developed resistance to treatment with a taxane (e.g., paclitaxel [Taxol®, Onxol®], docetaxel [Docefrez®, Taxotere®], albumin-bound paclitaxel [Abraxane®])?  Yes  No *If yes, no further questions*
9. Is the patient resistant to treatment with a taxane?  Yes  No

Section B: Monotherapy

10. Has the patient tried treatment with **ANY** of the following? **Indicate all below or mark "None of the above"**  
 **Anthracycline**® (e.g., doxorubicin [Adriamycin®], epirubicin [Ellence®], pegylated liposomal doxorubicin [Doxil®])  
 **Taxane**® (e.g., paclitaxel [Taxol®, Onxol®], docetaxel [Docefrez®, Taxotere®], albumin-bound paclitaxel [Abraxane®])  
 **Xeloda**® (capecitabine)  
 None of the above
11. **If ALL of the above have been tried**, is the breast cancer resistant or refractory to anthracycline, taxanes, and capecitabine?  Yes  No  Not applicable *If question is applicable, no further questions*

12. What is the patient's HER2 status?  
 Positive  Negative  Unknown **Action Required: Attach HER2 results to PA**
13. What is the hormone receptor status?  
 Positive  Negative  Unknown *If negative, no further questions*
14. Is the patient refractory to endocrine therapy?  Yes  No *If yes, no further questions*
15. Does the patient have symptomatic visceral disease or visceral crisis?  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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CUT9521-1E (4/15)