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}

Ixempra

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*

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

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

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
   - ❒ Breast cancer (If checked, go to 2)
   - ❒ Other, please specify. _____ (If checked, go to 2)

2. Is this a request for continuation of therapy with the requested medication?
   - ❒ Yes (If checked, go to 3)
   - ❒ No, (If checked, go to 4)
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   - ❒ Yes (If checked, *no further Questions*)
   - ❒ No (If checked, *no further questions*)
4. Will the requested medication be used in one of the following regimens?
   - ❒ As a single agent (If checked, go to 5)
   - ❒ In combination with trastuzumab (If checked, go to 7)
   - ❒ In combination with capecitabine (If checked, go to 9)
   - ❒ Other, please specify. _____ (If checked, *no further questions*)
5. What is the clinical setting in which the requested medication will be used?
   - ❒ Locally advanced disease (If checked, go to 6)
   - ❒ Recurrent disease (If checked, go to 6)
   - ❒ Metastatic disease (If checked, go to 6)
   - ❒ No response to preoperative systemic therapy (If checked, go to 6)
   - ❒ Other, please specify. _____ (If checked, go to 6)
6. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
   - ❒ HER2-positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
   - ❒ HER2-negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
   - ❒ Unknown (If checked, *no further questions*)
7. What is the clinical setting in which the requested medication will be used?
   - ❒ Recurrent disease (If checked, go to 8)
   - ❒ Metastatic disease (If checked, go to 8)
   - ❒ No response to preoperative systemic therapy (If checked, go to 8)
   - ❒ Other, please specify. _____ (If checked, go to 8)
8. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
   - ❒ HER2-positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
   - ❒ HER2-negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

9. What is the clinical setting in which the requested medication will be used?
   ❒ Locally advanced disease (If checked, go to 10)
   ❒ Metastatic disease (If checked, go to 10)
   ❒ Other, please specify. _____ (If checked, go to 10)
10. Has the patient failed therapy with an anthracycline and a taxane?
   ❒ Yes (If checked, go to 12)
   ❒ No (If checked, go to 11)
11. Does the patient have cancer that is taxane resistant and for which further anthracycline therapy is contraindicated?
   ❒ Yes (If checked, go to 12)
   ❒ No (If checked, go to 12)

12. Does the patient have an aspartate aminotransferase (AST) or an alanine aminotransferase (ALT) level greater than 2.5 times the upper limit of normal (ULN) or a bilirubin greater than one time the ULN?
   ❒ Yes (If checked, *no further questions*)
   ❒ No (If checked, *no further questions*)
   ❒ Unknown (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)**