Kadcyla

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*	❑ *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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Kadcyla SGM – 06/2021.

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Adjuvant treatment of early breast cancer
   - ❑ Recurrent or metastatic breast cancer
   - ❑ Non-small cell lung cancer
   - ❑ Salivary gland tumor
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for a continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions if patient has diagnosis of recurrent or metastatic breast cancer or non small cell lung cancer.*
5. How many months of the requested drug has the patient received? _____ *No further questions*

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

Section A: Breast Cancer

6. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ *HER2* positive ❑ *HER2* negative ❑ Unknown
7. Does the patient have early breast cancer? ❑ Yes ❑ No *If No, no further questions.*
8. Will the requested drug be used as adjuvant treatment of residual disease after neoadjuvant taxane and trastuzumab-based treatment? ❑ Yes ❑ No

Section B: Non-small Cell Lung Cancer

9. Does the patient have a confirmed human epidermal growth factor receptor 2 (HER2) mutation? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) mutations.*** ❑ Yes ❑ No

Section C: Salivary Gland Tumor

10. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
    ❑ *HER2* positive ❑ *HER2* negative ❑ Unknown
11. What is the clinical setting in which the requested drug will be used? ❑ Recurrent disease ❑ Other
12. Will the requested drug 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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