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*

Criteria Questions:

What is the ICD-10 code? _____

1. What is the patient's diagnosis?

❒ Breast cancer (If checked, go to 2)
❒ Non-small cell lung cancer (If checked, go to 2)
❒ Salivary gland tumor (If checked, go to 2)
❒ Other, please specify. _____ (If checked, go to 2)

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

 CareFirst Kadcyla SGM 1906-A – 07/2023.

2. Is the request for a continuation of therapy with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 6*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What is the patient's diagnosis?

❒ Adjuvant treatment of early breast cancer (If checked, go to 5)

❒ Recurrent or metastatic breast cancer (If checked, *no further questions*)

❒ Non-small cell lung cancer (If checked, *no further questions*)
❒ Salivary gland tumor (If checked, *no further questions*)

5. How many months has the patient received therapy with the requested medication?
_____months, *no further questions*

6. What is the patient's diagnosis?

❒ Breast cancer (If checked, go to 7)

❒ Non-small cell lung cancer (If checked, go to 15)
❒ Salivary gland tumor (If checked, go to 19)

7. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Please 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, go to 8)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)
❒ Unknown (If checked, go to 8)

8. Does the patient have early breast cancer?
❒ Yes, *Continue to 9*
❒ No, *Continue to 12*

9. Will the requested drug be used as adjuvant treatment?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Please indicate how many months of therapy with the requested drug the patient has previously been treated with:
_____months, *no further questions*

12. What is the clinical setting in which the requested drug will be used?

❒ Metastatic disease (If checked, go to 13)

❒ Recurrent disease (If checked, go to 13)

❒ The disease had no response to preoperative systemic therapy (If checked, go to 13)
❒ Other, please specify. _____ (If checked, go to 13)

13. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 14)
❒ Subsequent treatment (If checked, go to 14)

14. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Does the patient have a confirmed human epidermal growth factor receptor 2 (HER2) mutation? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) mutation status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 16)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 16)
❒ Unknown (If checked, go to 16)

16. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease (If checked, go to 17)

❒ Recurrent disease (If checked, go to 17)

❒ Metastatic disease (If checked, go to 17)
❒ Other, please specify. _____ (If checked, go to 17)

17. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 18)
❒ Subsequent treatment (If checked, go to 18)

18. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Please 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, go to 20)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 20)
❒ Unknown (If checked, go to 20)

20. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease (If checked, go to 21)
❒ Other, please specify. _____ (If checked, go to 21)

21. Will the requested drug be used as a single agent?

❒ 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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com