Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Lumakras

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Pancreatic Adenocarcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions.*

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

Section A: Non-Small Cell Lung Cancer (NSCLC)

5. How is the patient's disease classified?
   - ❑ Locally advanced disease
   - ❑ Metastatic disease
   - ❑ Other _____
6. Has the patient received at least one prior systemic therapy? ❑ Yes ❑ No
7. Does the patient's cancer have a KRAS G12C mutation ? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No ❑ Unknown
8. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Section C: Pancreatic Adenocarcinoma

9. What is the clinical setting in which the requested medication will be used?
   - ❑ Locally advanced disease
   - ❑ Recurrent disease
   - ❑ Metastatic disease
   - ❑ Other _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

10. Is the tumor or plasma specimen positive for the KRAS G12C mutation? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results confirming KRAS G12C mutation status.*** ❑ Yes ❑ No ❑ Unknown

11. What is the patient's Eastern Cooperative Oncology Group (ECOG) performance status?
    ❑ 0-2 ❑ 3 or greater

12. Will the requested medication 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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