Lynparza

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.

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Patient's Name: _____**Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis/indication?
   - ❑ Epithelial ovarian, fallopian tube, or primary peritoneal cancer ❑ Breast cancer
   - ❑ Pancreatic adenocarcinoma (pancreatic cancer) ❑ Prostate cancer
   - ❑ Uterine leiomyosarcoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. What clinical setting will the requested drug be used in?
   - ❑ Advanced (Stage II-IV) disease ❑ Metastatic disease ❑ Recurrent disease
   - ❑ As adjuvant therapy ❑ Metastatic disease
   - ❑ No response to preoperative systemic therapy
   - ❑ Other _____

4. What is the requested regimen?
   - ❑ Single agent
   - ❑ Single agent (concurrent use with a gonadotropin-releasing hormone (GnRH) analog is allowed)
   - ❑ In combination with abiraterone and prednisone or prednisolone
   - ❑ The requested medication in combination with bevacizumab (e.g., Avastin)
   - ❑ Other _____

5. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to #9*

6. *If the diagnosis is breast cancer,* is the requested medication being used for adjuvant treatment of early-stage, HER2-negative, BRCA-mutated breast cancer with high-risk of recurrence?
   ❑ Yes ❑ No ❑ N/A - diagnosis is NOT breast cancer

7. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No

8. How many months has the patient received therapy with the requested medication? _____ months

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9. Does the patient have deleterious or suspected deleterious germline or somatic BRCA mutation?
ACTION REQUIRED: If Yes, attach laboratory report confirming BRCA mutation status.
❑ Yes ❑ No ❑ Unknown ❑ N/A - Patient has prostate cancer

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

Section A: Breast Cancer

10. Will the requested drug be used as adjuvant therapy? ❑ Yes ❑ No

11. Does the patient have human epidermal growth factor receptor 2 (HER2) negative disease?
ACTION REQUIRED: If yes, attach test results or chart note(s) confirming HER2 negative disease.
❑ Yes ❑ No ❑ Unknown

12. Has the patient already completed neoadjuvant/adjuvant chemotherapy? ❑ Yes ❑ No

13. In which of the following settings will the requested medication be used?
❑ Hormone receptor-negative breast cancer with any residual disease
❑ Hormone receptor-negative breast cancer with either tumor size of 2cm or greater, or any involved axillary
❑ Hormone receptor-positive breast cancer with 4 or more positive lymph nodes
❑ Hormone receptor-positive breast cancer with any residual disease and a CPS+EG (clinical stage, pathologic stage, estrogen receptor status and tumor grade) score of 3 or greater following preoperative therapy
❑ Other _____

Section B: Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

Continuation

14. Is the requested medication being used for any of the following?
❑ First-line maintenance treatment of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in combination with bevacizumab
❑ First line maintenance treatment of advanced BRCA mutated epithelial ovarian, fallopian tube, or primary peritoneal cancer
❑ None of the above

15. Has the patient experienced a complete response while using the requested drug as first-line maintenance treatment?
❑ Yes ❑ No

16. How long has the patient been treated with the requested drug after achieving a complete response?
_____ years _____ months

Initiation

17. Is the requested medication being used as maintenance treatment? ❑ Yes ❑ No

18. Is the patient in a complete or partial response to chemotherapy? ❑ Yes ❑ No

19. How many prior lines of platinum-based therapy has the patient completed? _____ lines

20. Has the patient received bevacizumab (e.g. Avastin) during primary therapy? ❑ Yes ❑ No

Section C: Pancreatic Adenocarcinoma (Pancreatic Cancer)

21. Will the requested medication be used as maintenance therapy for pancreatic adenocarcinoma? ❑ Yes ❑ No

22. Has the patient received a first-line platinum-based chemotherapy (e.g., cisplatin, carboplatin) for at least 16 weeks?
❑ Yes ❑ No

23. Has the disease progressed during first line platinum based chemotherapy? ❑ Yes ❑ No

Section D: Prostate Cancer

24. Is the disease castration-resistant? ❑ Yes ❑ No

25. Does the patient have a deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation (e.g., BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, RAD54L)? ***ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming HRR mutation status.*** ❑ Yes ❑ No ❑ Unknown

26. Has the patient progressed on prior androgen receptor-directed therapy? ❑ Yes ❑ No

27. Does the patient have a deleterious or suspected deleterious BRCA mutation? ***ACTION REQUIRED: If Yes, attach test results or chart note(s) confirming BRCA mutation status.*** ❑ Yes ❑ No ❑ Unknown

28. Will the patient receive concurrent therapy with a gonadotropin-releasing hormone (GnRH) analog? ❑ Yes ❑ No

29. Has the patient had a bilateral orchiectomy? ❑ Yes ❑ No

Section E: Uterine Leiomyosarcoma

30. Does the patient have BRCA altered uterine leiomyosarcoma? ***ACTION REQUIRED: If Yes, attach laboratory report confirming BRCA mutation status.*** ❑ Yes ❑ No ❑ Unknown

31. Will the requested medication be used as second-line therapy? ❑ 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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