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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: _____**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?
   ❑ Breast cancer
   ❑ Other _____

2. What is the ICD-10 code? _____

3. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with all or at least three of the formulary medications. The formulary alternatives for the requested drug is a trial of one generic hormonal agent (anastrozole OR exemestane OR letrozole OR letrozole). Can the patient's treatment be switched to a formulary alternative? ***If Yes, indicate below and please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes, please specify: _____ ❑ No - Continue request non-formulary medication

4. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to all or at least three of the formulary alternative(s)? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative. ❑ Yes ❑ No

   Formulary alternative(s): a trial of one generic hormonal agent (anastrozole OR exemestane OR fulvestrant OR letrozole)

   If Yes, specify the formulary alternative(s) the patient has tried and the reason for treatment failure and skip to #6.

   Drug name: _____ Reason for treatment failure: _____

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

5. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): a trial of one generic hormonal agent (anastrozole OR exemestane OR fulvestrant OR letrozole)? ❑ Yes ❑ No

   If Yes, specify the formulary alternative(s) the patient is unable to take and describe the contraindication(s):

   Drug name: _____ Contraindication: _____

   Drug name: _____ Contraindication: _____

   Drug name: _____ Contraindication: _____

   Drug name: _____ Contraindication: _____

6. Has chart note(s) or other documentation supporting the inadequate response, intolerable adverse reaction or contraindication to the necessary number of formulary alternatives been submitted? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.***
   ❑ Yes ❑ No

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

8. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

9. What is the clinical setting in which the requested medication will be used?
   ❑ Advanced disease
   ❑ Metastatic disease
   ❑ Recurrent disease
   ❑ The patient had no response to preoperative systemic therapy
   ❑ Other _____

10. What is the tumor estrogen receptor (ER) status of the disease? ***ACTION REQUIRED: Please attach chart note(s) or test results of estrogen receptor (ER) status.***
    ❑ ER-positive ❑ ER-negative ❑ Unknown

11. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.***
    ❑ HER2 positive ❑ HER2 negative ❑ Unknown

12. Is the tumor estrogen receptor 1 (ESR1) mutated? ***ACTION REQUIRED: If Yes, please attach chart note(s) or test results of estrogen receptor 1 (ESR1) mutation status***. ❑ Yes ❑ No ❑ Unknown

13. Has the patient received at least one prior line of endocrine therapy (e.g., fulvestrant [Faslodex], anastrozole [Arimidex], letrozole [Femara], exemestane [Aromasin])? ❑ Yes ❑ No

14. 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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