# Padcev

## 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**



**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**

**Clinical Criteria Questions:**

1. What is the diagnosis?
   - ❑ Urothelial cancer - Bladder cancer
   - ❑ Urothelial cancer - Primary carcinoma of the urethra
   - ❑ Urothelial cancer - Upper genitourinary tract tumors
   - ❑ Urothelial cancer - Urothelial carcinoma of the prostate
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug? ❑ Yes ❑ No *No further questions*
5. Will the requested medication be used as a single agent? ❑ Yes ❑ No
6. What is the place in therapy in which the requested drug will be used?
   - ❑ First-line treatment
   - ❑ Subsequent treatment
7. Is the patient ineligible for cisplatin-containing chemotherapy? *If Yes, skip to #10* ❑ Yes ❑ No
8. Has the patient received prior treatment with a platinum-containing chemotherapy? ❑ Yes ❑ No
9. Has the patient received prior treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand (PD-L1) inhibitor? ❑ Yes ❑ No
10. What is the clinical setting in which the requested drug will be used?
    - ❑ Locally advanced disease
    - ❑ Recurrent disease
    - ❑ Metastatic disease
    - ❑ Stage II disease
    - ❑ Other _____
11. *If the diagnosis is bladder cancer*, will the drug be used for either of the following? *If Yes, no further questions*
    - ❑ Yes - Metastatic or local recurrence post-cystectomy
    - ❑ Yes - Muscle invasive local recurrence or persistent disease in a preserved bladder
    - ❑ No - None of the above
12. Is the tumor present following reassessment of tumor status 2-3 months after primary treatment with bladder preserving concurrent chemoradiotherapy? ❑ 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)**

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