Rozlytrek

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?
   ❑ Solid tumor with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion
   ❑ Non-small cell lung cancer ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the product being requested for the treatment of one of the following indications?
   ❑ Tumors with neurotrophic receptor kinase (NTRK) gene fusion
   ❑ C-ros oncogene 1 (ROS1)-positive non-small cell lung cancer (NSCLC)
   ❑ No *If No, skip to #10*
4. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Tumors with neurotrophic receptor kinase (NTRK) gene fusion: Vitrakvi
   b) C-ros oncogene 1 (ROS1)-positive non-small cell lung cancer (NSCLC): Xalkori

   Can the patient's treatment be switched to the preferred product? ***If Yes, 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 - Vitrakvi for NTRK ❑ Yes - Xalkori for NSCLC ❑ No - Continue request non-formulary medication
5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*
6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to #10*
7. Does the patient have a documented inadequate response to treatment with the preferred product?
   ACTION REQUIRED: If 'Yes', attach supporting chart note(s) and skip to #10. ❑ Yes ❑ No
8. Does the patient have a documented intolerable adverse event to the preferred product?
   ACTION REQUIRED: If 'Yes', attach supporting chart note(s) and skip to #10. ❑ Yes ❑ No
9. Does the patient have a documented clinical reason to avoid the preferred product?
   ACTION REQUIRED: If 'Yes', attach supporting chart note(s). ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

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

 Rozlytrek State Step, NTM SGM - 4/2020.

10. Does the patient have metastatic disease? ❑ Yes ❑ No

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

Section A: Solid Tumor with a Neurotrophic Receptor Tyrosine Kinase (NTRK) Gene Fusion

11. Has laboratory testing (e.g., next-generation sequencing [NGS] or fluorescence in situ hybridization [FISH]) demonstrated that the patient's tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation? ***ACTION REQUIRED: If Yes, attach test result.***
    ❑ Yes ❑ No ❑ Unknown

12. *If patient has metastatic disease,* is surgical resection likely to result in severe morbidity? ❑ Yes ❑ No

13. Is there any other satisfactory alternative treatment for the patient's disease?
    ❑ Yes ❑ No *If No, no further questions*

14. Has the disease progressed following standard systemic treatment for the patient's disease? ❑ Yes ❑ No

Section B: Non-Small Cell Lung Cancer

15. What is the tumor's ROS1 mutation status? ***ACTION REQUIRED: Attach test result.***
    ❑ Positive ❑ Negative ❑ Unknown

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?
    ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Vitrakvi for NTRK; Xalkori for NSCLC) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, no further questions*

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Vitrakvi for NTRK; Xalkori for NSCLC)?
    If Yes, indicate below and no further questions.
    ❑ The alternate drug is contraindicated
    ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
    ❑ The alternate drug is expected to be ineffective
    ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
    ❑ The alternate drug is not in the patient's best interest
    ❑ None of the above, *continue to #8*

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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 Prior Authorization Fax: 1-866-249-6155