Tibsovo

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?
   - ❑ Acute myeloid leukemia (AML)
   - ❑ Cholangiocarcinoma
   - ❑ Chondrosarcoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's age (physiologic age)? _____ years
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*
6. Will the requested medication be used as a single-agent? ❑ Yes ❑ No

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

Section A: Acute Myeloid Leukemia

7. Does patient's acute myeloid leukemia have a susceptible isocitrate dehydrogenase-1 (IDH1) mutation?
   ACTION REQUIRED: If Yes, attach medical record documentation of isocitrate dehydrogenase-1 (IDH1) mutation. ❑ Yes ❑ No ❑ Unknown
8. What is the clinical setting in which the requested medication will be administered?
   - ❑ Newly-diagnosed acute myeloid leukemia
   - ❑ Post-induction therapy for acute myeloid leukemia, *skip to #10*
   - ❑ Relapsed or refractory acute myeloid leukemia, *no further questions*
   - ❑ Other _____
9. Does the patient have comorbidities that preclude the use of intensive induction chemotherapy?
   If Yes, no further questions ❑ Yes ❑ No
10. Has the patient declined to receive intensive induction chemotherapy? ❑ Yes ❑ No *No further questions*

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

11. Has the patient experienced a response to therapy with the requested medication? ❑ Yes ❑ No

Section B: Cholangiocarcinoma

12. Does patient's cholangiocarcinoma have an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test? ***ACTION REQUIRED: If Yes, attach medical record documentation of isocitrate dehydrogenase-1 (IDH1) mutation test result.*** ❑ Yes ❑ No ❑ Unknown

13. Is the disease unresectable or metastatic? ❑ Yes ❑ No

14. What is the clinical setting in which the requested drug will be used?
    - ❑ As first-line treatment
    - ❑ As subsequent treatment
    - ❑ Other _____

Section C: Chondrosarcoma

15. Does the patient's chondrosarcoma have a susceptible isocitrate dehydrogenase-1 (IDH-1) mutation? ***ACTION REQUIRED: If Yes, attach medical record documentation of isocitrate dehydrogenase-1 (IDH1) mutation test result.*** ❑ Yes ❑ No ❑ Unknown

16. What is the clinical setting in which the requested medication will be administered?
    - ❑ Conventional (grades 1-3) chondrosarcoma
    - ❑ Dedifferentiated chondrosarcoma
    - ❑ Other _____

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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