Trodelvy

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*

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Breast cancer (If checked, go to 2)
❒ Urothelial carcinoma - Bladder cancer (If checked, go to 2)
❒ Urothelial carcinoma - Primary Carcinoma of the Urethra (If checked, go to 2)
❒ Urothelial carcinoma - Upper Genitourinary Tract Tumors (If checked, go to 2)
❒ Urothelial carcinoma - Urothelial Carcinoma (UC) of the Prostate (If checked, go to 2)
❒ Other, please specify. _____ (If checked, go to 2)

2. Is the request for continuation of therapy?

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❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Breast cancer (If checked, go to 5)

❒ Urothelial carcinoma - Bladder cancer (If checked, go to 14)

❒ Urothelial carcinoma - Primary Carcinoma of the Urethra (If checked, go to 19)

❒ Urothelial carcinoma - Upper Genitourinary Tract Tumors (If checked, go to 24)

❒ Urothelial carcinoma - Urothelial Carcinoma (UC) of the Prostate (If checked, go to 24)

5. Which of the following applies to the patient's disease?

❒ Triple negative breast cancer (If checked, go to 6)

❒ The cancer cells are hormone receptor positive (If checked, go to 9)

❒ Other, please specify. _____ (If checked, *no further questions*)

6. Does the patient have a diagnosis of triple-negative breast cancer confirmed by the breast cancer cells testing negative for ALL of the following receptors: A) human epidermal growth factor receptor 2 (HER2), B) estrogen, and C) progesterone? ***ACTION REQUIRED***: Please submit test results confirming triple negative breast cancer.

❒ Yes (If checked, go to 7)

❒ No (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

7. Has the patient received at least two prior therapies, with at least one line for metastatic disease?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. In which clinical setting will the requested drug be used?

❒ Recurrent disease (If checked, *no further questions*)

❒ Unresectable disease (If checked, *no further questions*)

❒ Metastatic disease (If checked, *no further questions*)

❒ The patient had no response to preoperative systemic (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

9. Is the human epidermal growth factor receptor 2 (HER2)-negative? ***ACTION REQUIRED***: If yes, please submit test results confirming status of human epidermal growth factor receptor 2 (HER2).

❒ Yes (If checked, go to 10)

❒ No (If checked, go to 10)

❒ Unknown (If checked, go to 10)

10. Has the patient received prior treatment with endocrine therapy (e.g., anastrozole [Arimidex], letrozole [Femara], fulvestrant [Faslodex])?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient received prior treatment with a CDK4/6 inhibitor (e.g., abemaciclib [Verzenio], palbociclib [Ibrance], ribociclib [Kisqali])?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Has the patient received prior treatment with at least two lines of chemotherapy (including a taxane) for advanced disease (e.g., paclitaxel, doxorubicin, gemcitabine)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. What is the clinical setting in which the requested drug will be used?

❒ Recurrent unresectable disease (If checked, *no further questions*)

❒ Metastatic disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

14. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. What is the place in therapy in which the requested drug be used?

❒ First-line treatment (If checked, go to 16)

❒ Subsequent treatment (If checked, go to 16)

16. In which clinical setting will the requested drug be used?

❒ Locally advanced disease (If checked, go to 17)

❒ Recurrent disease (If checked, go to 17)

❒ Persistent disease (If checked, go to 17)

❒ Metastatic disease (If checked, go to 17)

❒ Other, please specify. _____ (If checked, *no further questions*)

17. Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor?
❒ Yes, a programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo) (If checked, *no further questions*)
❒ Yes, a programmed death-ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq) (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

19. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the place in therapy in which the requested drug be used?

❒ First-line treatment (If checked, go to 21)

❒ Subsequent treatment (If checked, go to 21)

21. In which clinical setting will the requested drug be used?

❒ Locally advanced disease (If checked, go to 22)

❒ Recurrent disease (If checked, go to 22)

❒ Metastatic disease (If checked, go to 22)

❒ Other, please specify. _____ (If checked, go to 22)

22. Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death ligand 1 (PD-L1) inhibitor?
❒ Yes, a programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo) (If checked, *no further questions*)
❒ Yes, a programmed death ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq) (If checked, *no further questions*)
❒ No (If checked, *no further questions*)

24. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment (If checked, go to 26)
❒ Subsequent treatment (If checked, go to 26)

26. In which clinical setting will the requested drug be used?
❒ Locally advanced disease (If checked, go to 27)
❒ Metastatic disease (If checked, go to 27)
❒ Other, please specify. _____ (If checked, go to 27)

27. Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor?
❒ Yes, a programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo) (If checked, *no further questions*)
❒ Yes, a programmed death-ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq) (If checked, *no further questions*)
❒ No (If checked, *no further questions*)

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

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