CVS caremark™ {{PANUMCODE}}

Tukysa

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma
   - ❑ Other_____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions.*

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

Section A: Breast Cancer

5. What is the clinical setting in which the requested medication will be used?
   - ❑ Initial therapy
   - ❑ Subsequent therapy, *skip to #7*
   - ❑ Other _____
6. Does the patient have small asymptomatic brain metastases? *If Yes, skip to #8* ❑ Yes ❑ No
7. What is the clinical setting in which the requested medication will be used?
   - ❑ Recurrent unresectable disease
   - ❑ Advanced unresectable disease
   - ❑ Metastatic disease, including limited or extensive brain metastases
   - ❑ No response to preoperative systemic therapy
   - ❑ Other_____
8. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ HER2-Positive ❑ HER2-Negative ❑ Unknown

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9. Will the requested drug be used in combination with trastuzumab (Herceptin) and capecitabine (Xeloda)?
   ❑ Yes ❑ No

Section B: Colorectal Cancer

10. What is the clinical setting in which the requested medication will be used?
    ❑ Unresectable disease
    ❑ Advanced disease
    ❑ Metastatic disease
    ❑ Other _____

11. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***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 disease negative (wild-type) for RAS (KRAS and NRAS) and BRAF mutations? ***ACTION REQUIRED: Please attach chart note(s) or test results confirming negative (wild-type) RAS (KRAS and NRAS) and BRAF mutation status.*** ❑ Yes ❑ No ❑ Unknown

13. Will the requested drug be used in combination with trastuzumab (Herceptin)? ❑ Yes ❑ No

14. Is intensive therapy appropriate for the patient? ❑ Yes ❑ No *If No, no further questions.*

15. Has the patient experienced disease progression? ❑ 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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