CVS caremark™ {{PANUMCODE}}

Verzenio

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
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the clinical setting in which the requested medication will be used?
   - ❑ Early disease
   - ❑ Recurrent disease
   - ❑ Advanced disease
   - ❑ Metastatic disease
   - ❑ Other _____
4. Is this a request for continuation of therapy with the requested medication? *If Yes, skip to #7* ❑ Yes ❑ No
5. What is the patient's hormone receptor (HR) status? ***ACTION REQUIRED: Attach chart note(s) or test results of hormone receptor (HR) status.*** ❑ HR-positive ❑ HR-negative ❑ Unknown
6. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ HER2-positive ❑ HER2-negative ❑ Unknown *Skip to clinical setting section.*
7. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No

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

Section A: Recurrent, Advanced, or Metastatic Breast Cancer

8. Will the requested medication be given in any of the following regimens?
   - ❑ As monotherapy
   - ❑ In combination with fulvestrant, *no further questions.*
   - ❑ In combination with an aromatase inhibitor (e.g., letrozole, anastrazole, exemestane), *no further questions.*
   - ❑ Other _____

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9. Did the patient experience disease progression following endocrine therapy and prior chemotherapy in the metastatic setting? ❑ Yes ❑ No

Section B: Early Breast Cancer

Continuation

10. How many months has the patient received therapy with the requested medication? _____ months

Initial

11. Will the requested medication be used as adjuvant treatment? ❑ Yes ❑ No

12. Will the requested medication be given in combination with endocrine therapy (tamoxifen or an aromatase inhibitor [e.g., letrozole, anastrozole, exemestane])? ❑ Yes ❑ No ❑ Unknown

13. Does the patient have node positive disease?
    - ❑ Yes, four or more positive lymph nodes*, no further questions.*
    - ❑ Yes, one to three positive lymph nodes
    - ❑ No

14. Does the patient have any of the following?
    - ❑ Grade 3 disease
    - ❑ Tumor size of 5 cm or greater
    - ❑ None of the above

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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