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: _____ **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 patient's diagnosis?
   ❑ Breast cancer
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the requested drug being used to treat a patient with stage IV advanced, metastatic cancer with its use being consistent for an FDA-approved indication, the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage IV advanced metastatic cancer and/or is supported by peer-reviewed medical literature? *If Yes, no further questions* ❑ Yes ❑ No
4. Is the product being requested for the treatment of one of the following indications?
   ❑ Yes ❑ No *If No, skip to #14*
   a) Treatment of a post-menopausal woman with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer, in combination with an aromatase inhibitor
   b) Treatment of women hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer, in combination with fulvestrant
5. The preferred products for your patient's health plan are Ibrance and Kisqali. Can the patient's treatment be switched to a 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 - Ibrance ❑ Yes - Kisqali ❑ No - Continue request for Verzenio
6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*
7. 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 #14*
8. Is the member requesting Verzenio for use in combination with an aromatase inhibitor as initial endocrine-based therapy? ❑ Yes ❑ No *If No, skip to #10*

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9. Does the patient have a documented inadequate response or intolerable adverse event to treatment with both of the preferred products (Ibrance and Kisqali)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #14.*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

10. Is the member requesting Verzenio for use in combination with fulvestrant for disease progression following endocrine therapy in a pre/perimenopausal woman? ❑ Yes ❑ No *If No, skip to #12*

11. Does the patient have a documented inadequate response or intolerable adverse event to treatment with Ibrance? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #14.***
❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

12. Is the member requesting Verzenio for use in combination with fulvestrant for disease progression following endocrine therapy in a postmenopausal woman? ❑ Yes ❑ No *If No, skip to #14*

13. Does the patient have a documented inadequate response or intolerable adverse event to treatment with both of the preferred products (Ibrance and Kisqali)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

14. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #16*

15. Has the patient experienced disease progression or an unacceptable toxicity with the requested medication?
❑ Yes ❑ No *No further questions*

16. Does the patient have recurrent, advanced, or metastatic disease?
❑ Recurrent disease ❑ Advanced disease ❑ Metastatic disease ❑ None of the above

17. What is the patient's hormone receptor (HR) status? ***ACTION REQUIRED: Attach hormone receptor testing results.*** ❑ HR-positive ❑ HR-negative ❑ Unknown

18. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Attach human epidermal growth factor receptor 2 (HER2) testing results.***
❑ HER2-positive ❑ HER2-negative ❑ Unknown

19. 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*

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

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 (Ibrance and Kisqali) FDA-approved for the medical condition being treated?
❑ Yes ❑ No *If No, please specify:* _____

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*

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7. Are any of the following conditions met for the alternate drug (Ibrance and Kisqali)?
   - ❑ 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

   If Yes, please specify: _____

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)**

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