Yonsa

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?
   ❑ Metastatic castration-resistant prostate cancer
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. Will the requested medication be used in combination with either of the following classes of medication?
   ❑ Second-generation oral anti-androgen (e.g., apalutamide [Erleada])
   ❑ Oral androgen metabolism inhibitor (e.g., abiraterone acetate [Zytiga])
   ❑ No
4. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
5. Has the patient experienced disease progression or an unacceptable toxicity while receiving therapy with the requested medication? ❑ Yes ❑ No *No further questions.*
6. Has the patient had a bilateral orchiectomy? *If Yes, no further questions.* ❑ Yes ❑ No
7. Will the requested medication be used in combination with a GnRH analog? ❑ 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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Yonsa SGM - 1/2023.