Member Name: **DOB:** **PA Number:**

Zejula

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 diagnosis?
   - ❑ Epithelial ovarian, fallopian tube, or primary peritoneal cancer
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ❑ Yes ❑ No *No further questions*
5. What clinical setting will the requested drug be used?
   - ❑ Persistent disease
   - ❑ Recurrent disease
   - ❑ Stage II-IV disease
   - ❑ Other _____
6. Is Zejula being used as maintenance treatment? ❑ Yes ❑ No *If No, skip to #9*
7. Is the patient in a complete or partial response to chemotherapy? ❑ Yes ❑ No
8. Will the requested drug be used as a single agent? ❑ Yes ❑ No *No further questions*
9. What chemotherapy regimen is being requested?
   - ❑ Zejula as a single agent
   - ❑ Zejula in combination with bevacizumab (e.g. Avastin), *skip to #14*
   - ❑ Other _____
10. How many prior chemotherapy regimens has the patient received? _____
11. Is the patient's cancer positive for homologous recombination deficiency (HRD)? ***ACTION REQUIRED: If Yes, attach laboratory report confirming HRD deficiency.*** ❑ Yes ❑ No ❑ Unknown

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

Member Name: **DOB:** **PA Number:**

12. Does the tumor have deleterious or suspected deleterious BRCA mutation (germline, somatic, or both)?
    ACTION REQUIRED: If Yes, attach laboratory report confirming BRCA mutation status.
    If Yes, no further questions. ❑ Yes ❑ No ❑ Unknown
13. Does the patient have genomic instability and has progressed more than 6 months after a response to the last platinum-based chemotherapy? ❑ Yes ❑ No *No further questions*
14. Is the disease platinum-sensitive? ❑ 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