Zoladex

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Prostate cancer
   - ❑ Breast cancer
   - ❑ Dysfunctional uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only)
   - ❑ Chronic anovulatory uterine bleeding (use as an endometrial thinning agent) (3.6 mg dose only)
   - ❑ Preservation of ovarian function (3.6 mg dose only)
   - ❑ Prevention of recurrent menstrual related attacks in acute porphyria (3.6 mg dose only)
   - ❑ Uterine leiomyomata (fibroids) (3.6 mg dose only)
   - ❑ Endometriosis (3.6 mg dose only)
   - ❑ Gender dysphoria
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What dose of Zoladex is being prescribed?
   - ❑ Zoladex 3.6 mg
   - ❑ Zoladex 10.8 mg *Skip to #8*
4. Is this a request for continuation of therapy with Zoladex 3.6 mg? ❑ Yes ❑ No *If No, Skip to diagnosis section*
5. *If the diagnosis is Preservation of ovarian function,* is the patient premenopausal and still undergoing chemotherapy? ❑ Yes ❑ No *No further questions*
6. *For all other diagnosis besides Gender dysphoria or preservation of ovarian function,* has the patient experienced clinical benefit while receiving the requested drug? ❑ Yes ❑ No
   For gender dysphoria, skip to diagnosis section
7. Has the patient experienced an unacceptable toxicity while receiving the requested drug? ❑ Yes ❑ No
8. Is this a request for continuation of therapy with Zoladex 10.8 mg? ❑ Yes ❑ No *If No, Skip to diagnosis section*
9. Does the patient have a diagnosis of gender dysphoria? *If Yes, skip to diagnosis section* ❑ Yes ❑ No
10. Has the patient experienced clinical benefit while receiving the requested drug? ❑ Yes ❑ No
11. Has the patient experienced an unacceptable toxicity while receiving the requested drug? ❑ Yes ❑ No

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

Section A: Breast Cancer

12. What is the patient's hormone receptor (HR) status? ❑ Positive ❑ Negative ❑ Unknown

Section B: Endometrial thinning agent (3.6 mg dose only)

13. Will Zoladex 3.6 mg be used as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding? *If Yes, no further questions* ❑ Yes ❑ No
14. Will Zoladex 3.6 mg be used for treatment of chronic anovulatory uterine bleeding in a patient with severe anemia? ❑ Yes ❑ No

Section C: Endometriosis (3.6 mg dose only)

15. For how many months has the patient already received Zoladex 3.6 mg for this indication? _____ months

Section D: Uterine leiomyomata (fibroids)

16. Will Zoladex 3.6 mg be given prior to surgery? ❑ Yes ❑ No

Section E: Preservation of ovarian function

17. Is the patient premenopausal and undergoing chemotherapy? ❑ Yes ❑ No

Section F: Gender Dysphoria

18. Is Zoladex being prescribed for pubertal hormonal suppression in an adolescent patient? ❑ Yes ❑ No
    If No, skip to #20

19. Which Tanner Stage of puberty has the patient reached?
❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions*

20. Is the patient undergoing gender transition? ❑ Yes ❑ No

21. Will the patient receive Zoladex concomitantly with gender-affirming hormones? ❑ Yes ❑ No

Section G: Prevention of recurrent menstrual related attacks in acute porphyria

22. Is Zoladex being requested to prevent recurrent menstrual related attacks in acute porphyria? ❑ Yes ❑ No

23. Is Zoladex being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
❑ 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 Specialty Programs Fax: 1-855-330-1720

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