



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.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____

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 Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Exception Criteria Questions:

- A. Is the product being requested for the treatment of prostate cancer?
 Yes No *If No, skip to Clinical Criteria Questions*
- B. The preferred product for your patient's health plan is Eligard. Can the patient's treatment be switched to the preferred product?
If Yes, please obtain Form for preferred product and submit for corresponding PA. Yes No
- C. Is this request for continuation of therapy with the requested product? Yes No, *If No, skip to Question E*
- D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. Yes No, *skip to Clinical Criteria Questions*
- E. Does the patient have a documented hypersensitivity to the preferred product (Eligard)? **ACTION REQUIRED: If Yes, please attach supporting chart note(s).** Yes No

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

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
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Clinical Criteria Questions:

1. What dose of Zoladex is being prescribed?
 Zoladex 3.6 mg
 Zoladex 10.8 mg
2. 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)
 Endometriosis (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)
 Gender dysphoria
 Other _____
3. What is the ICD-10 code? _____
For a diagnosis of endometrial thinning, endometriosis, uterine leiomyomata (fibroids) or gender dysphoria skip to diagnosis section.
4. Is this a request for continuation of therapy with the requested dose of Zoladex?
 Yes No *If No, skip to diagnosis section.*
5. *If diagnosis is preservation of ovarian function (3.6 mg dose only), is the patient premenopausal and still undergoing chemotherapy?* Yes No *No further questions*
6. *If diagnosis is prostate cancer, has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)?* Yes No *Any answer, skip to #8*
7. Has the patient experienced clinical benefit while receiving the requested drug? Yes No
8. 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

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

Section B: Endometrial Thinning Agent (3.6 mg dose only)

10. 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
11. 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)

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

Section D: Uterine Leiomyomata (Fibroids, 3.6 mg dose only)

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

Section E: Preservation of Ovarian Function (3.6 mg dose only)

14. Is the patient premenopausal and undergoing chemotherapy? Yes No

Section F: Gender Dysphoria

15. Is this a request for continuation of therapy with the requested dose of Zoladex? Yes No
16. Is Zoladex being prescribed for pubertal hormonal suppression in an adolescent patient?
 Yes No *If No, skip to #18*

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

18. Is the patient undergoing gender transition? Yes No

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

Section G: Prevention of Recurrent Menstrual Related Attacks in Acute Porphyria (3.6 mg only)

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

21. Is Zoladex being prescribed by, or in consultation with, a physician experienced in the management of porphyrias?
 Yes No

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
	Yes	No
Is the requested drug being used to treat stage four advanced metastatic cancer?		
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?		
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)?		
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)?		
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?		
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?		

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Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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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