Bavencio

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* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is this request to continue previously established treatment with the requested medication?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested medication). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested medication for 6 months). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested medication for 7 months or greater – initial 6 months plus 45 days grace period).

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

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C. Is the patient receiving provider administered combination chemotherapy? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?
   - ❑ Merkel cell carcinoma
   - ❑ Urothelial carcinoma-Bladder cancer
   - ❑ Urothelial carcinoma-Primary carcinoma of the urethra
   - ❑ Urothelial carcinoma-Upper Genitourinary Tract Tumors
   - ❑ Urothelial carcinoma of the Prostate
   - ❑ Renal Cell Carcinoma
   - ❑ Gestational trophoblastic neoplasia
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while receiving another PD-1 or PD-L1 inhibitor (e.g., Opdivo, Imfinzi)? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions*

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

Section A: Merkel cell carcinoma

6. What is the clinical setting in which the requested drug will be used?
   - ❑ Metastatic disease
   - ❑ Recurrent disseminated disease
   - ❑ Other _____

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Section B: Urothelial Carcinoma-Bladder Cancer

7. Will the requested drug be used as a single agent? ❑ Yes ❑ No

8. Will the requested medication be used as maintenance therapy? ❑ Yes ❑ No *If No, skip to #10*

9. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
   ❑ Yes ❑ No *No further questions*

10. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

11. What is the clinical setting in which the requested drug will be used?
    ❑ Locally advanced disease *No further questions*
    ❑ Metastatic disease *No further questions*
    ❑ Post-cystectomy
    ❑ Preserved bladder *Skip to #13*
    ❑ Stage II or IIIA disease *Skip to #14*
    ❑ Other

12. What is the clinical setting in which the requested drug will be used following cystectomy? *No further questions*
    ❑ Metastatic disease ❑ Local recurrence ❑ Other

13. What is the clinical setting in which the requested drug will be used in a preserved bladder? *No further questions*
    ❑ Muscle invasive local recurrent
    ❑ Muscle invasive persistent disease
    ❑ Other

14. Is tumor present following primary bladder preserving chemoradiation? ❑ Yes ❑ No

Section C: Urothelial carcinoma – Primary carcinoma of the urethra

15. Will the drug be used as a single agent? ❑ Yes ❑ No

16. Will the requested medication be used as maintenance therapy? ❑ Yes ❑ No *If No, skip to #18*

17. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
    ❑ Yes ❑ No *No further questions*

18. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

19. What is the clinical setting in which the requested drug will be used?
    ❑ Recurrent disease
    ❑ Locally advanced disease
    ❑ Metastatic disease
    ❑ Other

Section D: Urothelial carcinoma- Upper Genitourinary Tract Tumors or Urothelial Carcinoma of the Prostate

20. Will the requested drug be used as a single agent? ❑ Yes ❑ No

21. Will the requested medication be used as maintenance therapy ❑ Yes ❑ No *If No, skip to #23*

22. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
    ❑ Yes ❑ No *No further questions*

23. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

24. What is the clinical setting in which the requested drug will be used?
    ❑ Locally advanced disease ❑ Metastatic disease ❑ Other

Section E: Renal Cell Carcinoma

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25. What is the clinical setting in which the requested drug will be used?
    - ❑ Advanced disease
    - ❑ Relapsed disease
    - ❑ Stage IV disease
    - ❑ Other

26. What is the place in therapy in which the requested drug will be used?
    - ❑ First-line treatment ❑ Subsequent treatment

27. Will the drug be used in combination with axitinib? ❑ Yes ❑ No

Section F: Gestational Trophoblastic Neoplasia

28. Will the requested drug be used as a single agent? ❑ Yes ❑ No

29. Is the disease resistant to multiagent chemotherapy? ❑ Yes ❑ No

30. What type of disease does the patient have?
    - ❑ Intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor)
    - ❑ High-risk disease *No further questions*
    - ❑ Other

31. What is the clinical setting in which the requested drug will be used?
    - ❑ Recurrent disease
    - ❑ Progressive disease
    - ❑ Other

32. Has the patient previously received treatment with a platinum/etoposide-containing regimen? ❑ 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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