Docetaxel

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*

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

 Docetaxel SGM 1091-A - 02/2023.

Criteria Questions:

1. What is the prescribed medication?
   ❑ Taxotere (docetaxel) ❑ Docefrez (docetaxel) ❑ docetaxel (generic) ❑ Other _____

2. What is the patient's diagnosis?
   ❑ Breast cancer
   ❑ Prostate cancer
   ❑ Non-small cell lung cancer (NSCLC)
   ❑ Gastric cancer
   ❑ Esophageal and esophagogastric junction cancer
   ❑ Epithelial ovarian cancer
   ❑ Fallopian tube cancer
   ❑ Primary peritoneal cancer
   ❑ Malignant sex-cord stromal tumor
   ❑ Malignant germ cell tumor residual disease
   ❑ Carcinosarcoma (malignant mixed Müllerian tumors)
   ❑ Clear cell carcinoma of the ovary
   ❑ Mucinous carcinoma of the ovary
   ❑ Small bowel adenocarcinoma
   ❑ Low-grade serous carcinoma
   ❑ Uterine neoplasm (including endometrial carcinoma and uterine sarcoma)
   ❑ Soft tissue sarcoma (including angiosarcoma, extremity/body wall, head/neck, retroperitoneal/intra-abdominal, pleomorphic rhabdomyosarcoma, dermatofibrosarcoma protuberans (DFSP) with fibrosarcomatous transformation and solitary fibrous tumor)
   ❑ Head and neck cancer (including very advanced head and neck cancer, cancers of the lip (mucosa), oral cavity, salivary gland, oropharynx, hypopharynx, nasopharynx, glottic larynx, and supraglottic larynx)
   ❑ Bladder cancer
   ❑ Urothelial carcinoma of the prostate
   ❑ Upper genitourinary tract tumor
   ❑ Primary carcinoma of the urethra
   ❑ Ewing's sarcoma
   ❑ Osteosarcoma
   ❑ Small cell lung cancer
   ❑ Thyroid carcinoma-anaplastic carcinoma
   ❑ Occult primary tumor (cancer of unknown primary)
   ❑ Grade 1 endometrioid carcinoma
   ❑ Anal cancer
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #6*.

5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*.

6. What is the clinical setting in which the requested medication will be used? ***Indicate ALL that apply.***
   ❑ Advanced disease
   ❑ Metastatic disease
   ❑ Progressive disease
   ❑ Recurrent disease
   ❑ Recurrent unresectable disease
   ❑ Refractory disease
   ❑ Relapsed disease
   ❑ The patient has had no response to preoperative systemic therapy
   ❑ Unresectable locally recurrent disease
   ❑ None of the above

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

Section A: Breast Cancer

7. Will the requested medication be given in any of the following regimens? ***Indicate ALL that apply.***
   ❑ As a single agent
   ❑ As adjuvant therapy
   ❑ As preoperative therapy
   ❑ In combination with capecitabine
   ❑ In combination with pertuzumab and trastuzumab
   ❑ In combination with trastuzumab
   ❑ None of the above

8. Will the requested medication be used as a substitute for other taxanes (e.g., paclitaxel or albumin-bound paclitaxel) due to medical necessity? *If Yes, no further questions* ❑ Yes ❑ No.

9. What is the patient's human epidermal growth factor receptor 2 (HER2) status?
   ❑ HER2-positive
   ❑ HER2-negative
   ❑ Unknown

Section B: Anal Cancer

10. What is the patient's disease histology?
    ❑ Squamous cell carcinoma
    ❑ Non-squamous cell carcinoma

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