Eligard

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

Criteria Questions:

1. Please indicate the strength being requested: ❑ 7.5mg ❑ 22.5mg ❑ 30mg ❑ 45mg
2. What is the ICD-10 code? _____
3. What is the diagnosis?
   ❑ Prostate cancer ❑ Gender dysphoria *Skip to Diagnosis section*
   ❑ Recurrent salivary gland tumors ❑ Other _____
4. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No and diagnosis is recurrent salivary gland tumors, skip to diagnosis section; If No and diagnosis is Prostate cancer, no further questions.*
5. Has the patient experienced clinical benefit while receiving the requested drug? ❑ Yes ❑ No
6. Has the patient experienced an unacceptable toxicity while receiving the requested drug?
   ❑ Yes ❑ No *No further questions*

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

Section A: Gender Dysphoria

7. Is Eligard prescribed for pubertal hormonal suppression in an adolescent patient?
   ❑ Yes ❑ No *If No, skip to #9*
8. Which Tanner Stage of puberty has the patient reached? ***Indicate below and no further questions***
   ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions*
9. Is the patient undergoing gender transition? ❑ Yes ❑ No
10. Will the patient receive Eligard concomitantly with gender-affirming hormones? ❑ Yes ❑ No

Section B: Recurrent Salivary Gland Tumors

11. Is the tumor androgen receptor positive? ❑ 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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