

**Eloxatin (oxaliplatin)  
Prior Authorization Request**

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

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 **1-866-814-5506**. 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:** \_\_\_\_\_

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

**Additional Demographic Information:**

*Patient Weight:* \_\_\_\_\_ *kg*  
*Patient Height:* \_\_\_\_\_ *ft* \_\_\_\_\_ *inches*

**Criteria Questions:**

1. What is the prescribed medication?  Eloxatin  Oxaliplatin (generic)  Other  
 \_\_\_\_\_
2. What is the diagnosis?  
 Colon cancer  
 Rectal Cancer  
 Pancreatic adenocarcinoma  
 Esophageal or esophagogastric junction cancer  
 Gastric cancer  
 Cholangiocarcinoma (intra- or extra-hepatic)  
 Gallbladder cancer  
 Neuroendocrine tumor of pancreas  
 Non-Hodgkin's lymphoma  
 Occult primary (cancer of unknown primary)  
 Epithelial ovarian cancer/ fallopian tube cancer/ primary peritoneal cancer  
 Testicular cancer  
 Non-urothelial cell bladder cancer  
 Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_

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*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)**