

**Gemcitabine
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?
 Gemzar gemcitabine (generic) Other _____

2. What is the patient's diagnosis?

<input type="checkbox"/> Pancreatic adenocarcinoma <input type="checkbox"/> Cholangiocarcinoma (intra- or extra-hepatic) <input type="checkbox"/> Non-small cell lung cancer (NSCLC) <input type="checkbox"/> Soft tissue sarcoma (STS) <input type="checkbox"/> Ewing's sarcoma <input type="checkbox"/> Hodgkin lymphoma <input type="checkbox"/> Malignant pleural mesothelioma <input type="checkbox"/> Dermatofibrosarcoma protuberans (DFSP) <input type="checkbox"/> Testicular cancer <input type="checkbox"/> Uterine sarcoma <input type="checkbox"/> Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer <input type="checkbox"/> Bladder cancer (includes primary carcinoma of the urethra, upper genitourinary tract tumors, and urothelial carcinoma of the prostate) <input type="checkbox"/> Other _____	<input type="checkbox"/> Recurrent or metastatic breast cancer <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Small cell lung cancer (SCLC) <input type="checkbox"/> Osteosarcoma <input type="checkbox"/> Nasopharyngeal cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Non-Hodgkin's lymphoma (NHL) <input type="checkbox"/> Occult primary tumor (cancer of unknown primary) <input type="checkbox"/> Thymoma/thymic carcinoma <input type="checkbox"/> Cervical cancer
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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)