Herceptin, Kanjinti, Ogivri

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

 Herceptin, Kanjinti, Ogivri SGM – 02/2020.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the prescribed drug? ❑ Herceptin ❑ Kanjinti ❑ Ogivri
2. What is the patient's diagnosis?
   ❑ Breast cancer
   ❑ Esophageal, gastric or gastroesophageal junction cancer
   ❑ Uterine serous carcinoma
   ❑ Salivary gland tumor
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is the request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #9*
5. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
6. Is the requested drug being used as neoadjuvant or adjuvant treatment of breast cancer?
   ❑ Yes ❑ No *If No, no further questions*
7. How many months of trastuzumab therapy has the patient received? _____ months
8. Has the patient received the requested drug for 12 months (52 weeks) or greater?
   ❑ Yes ❑ No *No further questions*
9. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ HER2 positive ❑ HER2 negative ❑ Unknown

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

Section A: Breast Cancer

10. Will the requested drug be used for the intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer? *If Yes, no further questions* ❑ Yes ❑ No
11. In which clinical setting will the requested drug be used?
    ❑ Preoperative/neoadjuvant treatment
    ❑ Adjuvant treatment*, skip to #13*
    ❑ Treatment of recurrent or metastatic disease, *no further questions*
    ❑ Other _____
12. Will the requested drug be used as part of a complete treatment regimen? ❑ Yes ❑ No
13. Has the patient received the requested drug for 12 months (52 weeks) or greater as adjuvant therapy?
    ❑ Yes ❑ No

Section B: Esophageal, Gastric, or Gastroesophageal Junction Cancer

14. Will the requested drug be used in combination with chemotherapy? ❑ Yes ❑ No

Section C: Uterine Serous Sarcoma

15. Does the patient have advanced or recurrent disease?
    ❑ Advanced disease
    ❑ Recurrent disease
    ❑ None of the above
16. Will the requested drug be used in combination with carboplatin and paclitaxel? ❑ Yes ❑ No

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Section D: Salivary Gland Tumors

17. Does the patient have recurrent disease? ❑ Yes ❑ No

18. Does the patient have distant metastases? ❑ 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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