



Imfinzi

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.

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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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Imfinzi SGM – 12/2020.

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 diagnosis?
 Urothelial carcinoma - Bladder cancer
 Urothelial carcinoma - Primary carcinoma of the urethra
 Urothelial carcinoma - Upper genitourinary tract tumors
 Urothelial carcinoma - Urothelial carcinoma of the prostate
 Non-small cell lung cancer
 Extensive-stage small cell lung cancer (ES-SCLC)
 Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo)?
 Yes No
4. Is the patient currently receiving treatment with the requested medication? Yes No *If No, skip to #8*
5. *If diagnosis is non-small cell lung cancer*, how many months of treatment has the patient received? _____ months
6. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? Yes No *No further questions*
7. What is the clinical setting in which the requested drug will be used?
 Locally advanced disease Metastatic disease
 Recurrent disease Unresectable Stage III disease
 Other _____
8. What is the place in therapy in which the requested drug will be used?
 First-line treatment
 Subsequent treatment
 Other _____

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

Section A: Bladder Cancer, Primary Carcinoma of the Urethra, Upper Genitourinary Tract Tumors, or Carcinoma of the Prostate

9. Will the requested drug be used as a single agent? Yes No
10. Has the patient previously received platinum-containing chemotherapy? Yes No
11. *If the diagnosis is bladder cancer*, will the drug be used for either of the following?
 - Metastatic or local recurrence post-cystectomy
 - Muscle invasive local recurrence or persistent disease in a preserved bladder Yes No

Section B: Non-Small Cell Lung Cancer

12. Has the disease progressed following concurrent platinum-based chemotherapy and radiation therapy?
 Yes No

Section C: Extensive-Stage Small Cell Lung Cancer

13. Will the requested drug be used in combination with etoposide and either carboplatin or cisplatin followed by single agent maintenance? 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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