

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

## Lynparza 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 1-866-249-6155.** 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: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}  
Patient's ID {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}  
Physician's Name: {{PHYFIRST}} {{PHYLAST}}  
Specialty: \_\_\_\_\_, NPI#: \_\_\_\_\_  
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}  
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis/indication?  
☐ Epithelial ovarian, fallopian tube, or primary peritoneal cancer  
☐ Breast cancer  
☐ Pancreatic adenocarcinoma (pancreatic cancer)  
☐ Prostate cancer  
☐ Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. What clinical setting will the requested drug be used in?  
☐ Early-stage disease ☐ Stage II-IV disease ☐ Recurrent disease ☐ Metastatic disease  
☐ Other \_\_\_\_\_
4. Will the requested drug be used as a:  
☐ Single agent (concurrent use with a gonadotropin-releasing hormone (GnRH) analog is allowed)  
☐ Lynparza + bevacizumab ☐ Other \_\_\_\_\_
5. Is the patient currently receiving treatment with the requested medication?  
☐ Yes ☐ No *If No, skip to #9*
6. Is the requested medication being used for adjuvant treatment of early-stage, HER2-negative, BRCA-mutated breast cancer with high-risk of recurrence? ☐ Yes ☐ No
7. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ☐ Yes ☐ No
8. How many months has the patient received therapy with Lynparza? \_\_\_\_\_ months
9. Does the patient have deleterious or suspected deleterious germline or somatic BRCA mutation?  
**ACTION REQUIRED: If Yes, attach laboratory report confirming BRCA mutation status.**  
☐ Yes ☐ No ☐ Unknown ☐ Not applicable - Patient has prostate cancer

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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

Section A: Breast Cancer

10. Will the requested drug be used as adjuvant therapy? ☐ Yes ☐ No
11. Does the patient have HER2 negative disease? ☐ Yes ☐ No
12. Has the patient already completed neoadjuvant/adjuvant chemotherapy and local treatment (e.g., radiation, surgery, etc.)? ☐ Yes ☐ No
13. Is the patient at high-risk for recurrent breast cancer? ☐ Yes ☐ No
14. In which of the following high-risk settings will the requested medication be used?
- ☐ Hormone receptor-negative breast cancer with either tumor size greater than or equal to 2cm or any involved axillary nodes
  - ☐ Hormone receptor-positive breast cancer with greater than or equal to 4 positive lymph nodes
  - ☐ Any residual disease and a CPS+EG (clinical stage, pathologic stage, estrogen receptor status and tumor grade) score greater than or equal to 3 following preoperative therapy
  - ☐ Other \_\_\_\_\_

Section B: Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

Continuation

15. Is the requested medication being used for any of the following?
- ☐ First-line maintenance treatment of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in combination with bevacizuma
  - ☐ First line maintenance treatment of advanced BRCA mutated epithelial ovarian, fallopian tube, or primary peritoneal cancer
  - ☐ None of the above
16. Has the patient experienced a complete response while using the requested drug as first -line maintenance treatment? ☐ Yes ☐ No
17. How long has the patient been treated with the requested drug after achieving a complete response?  
\_\_\_\_\_ years \_\_\_\_\_ months

Initiation

18. Is the requested medication being used as maintenance treatment? *If Yes, skip to #14* ☐ Yes ☐ No
19. How many prior chemotherapies has the patient received? \_\_\_\_\_
20. Is the patient in a complete or partial response to chemotherapy? ☐ Yes ☐ No
21. How many prior lines of platinum-based therapy has the patient completed? \_\_\_\_\_
22. Has the patient received bevacizumab (e.g. Avastin) during primary therapy? ☐ Yes ☐ No

Section C: Pancreatic Cancer

23. Has the patient received a first-line platinum based chemotherapy for at least 16 weeks? ☐ Yes ☐ No
24. Has the disease progressed during first line platinum based chemotherapy? ☐ Yes ☐ No

Section D: Prostate Cancer

25. Is the disease castration-resistant? ☐ Yes ☐ No
26. Does the patient have a deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene mutation (e.g. BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, RAD54L)? **ACTION REQUIRED: If Yes, attach laboratory report confirming HRR mutation status.** ☐ Yes ☐ No ☐ Unknown
27. Has the patient progressed on prior androgen receptor-directed therapy? ☐ Yes ☐ No

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28. Will the patient receive concurrent therapy with a gonadotropin-releasing hormone (GnRH) analog?

☐ Yes ☐ No

29. Has the patient had a bilateral orchiectomy? ☐ 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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