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

CVS caremark™ {{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.

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: {{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?
   - ❑ 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. 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
6. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
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

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

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

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

Continuation

9. 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
10. Has the patient experienced a complete response while using the requested drug as first -line maintenance treatment? ❑ Yes ❑ No
11. How long has the patient been treated with the requested drug after achieving a complete response?
    _____ years _____ months

Initiation

12. Is the requested medication being used as maintenance treatment? *If Yes, skip to #14* ❑ Yes ❑ No
13. How many prior chemotherapies has the patient received? _____
14. Is the patient in a complete or partial response to chemotherapy? ❑ Yes ❑ No
15. How many prior lines of platinum-based therapy has the patient completed? _____
16. Has the patient received bevacizumab (e.g. Avastin) during primary therapy? ❑ Yes ❑ No

Section B: Pancreatic Cancer

17. Has the patient received a first-line platinum based chemotherapy for at least 16 weeks? ❑ Yes ❑ No
18. Has the disease progressed during first line platinum based chemotherapy? ❑ Yes ❑ No

Section C: Prostate Cancer

19. Is the disease castration-resistant? ❑ Yes ❑ No
20. 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
21. Has the patient progressed on prior androgen receptor-directed therapy? ❑ Yes ❑ No
22. Will the patient receive concurrent therapy with a gonadotropin-releasing hormone (GnRH) analog?
    ❑ Yes ❑ No
23. 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)**

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