CVS/caremark™

2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Margenza

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Exception Criteria Questions:

A. Is the product being requested for the treatment of breast cancer?
❑ Yes ❑ No *If No, skip to Criteria Questions*

B. The preferred products for your patient's health plan are Enhertu, Kadcyla, Perjeta, and Phesgo. Can the patient's treatment be switched to any of the preferred products?
❑ Yes – Enhertu, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ Yes – Kadcyla, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ Yes – Perjeta, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ Yes – Phesgo, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ No

C. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to letter E*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to Criteria Questions*

E. Does the patient have a documented inadequate response or intolerable adverse event to treatment with at least three of the preferred products (Enhertu, Kadcyla, Perjeta, and Phesgo)? ***Action Required: If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
   ❒ Breast cancer (*If checked, go to 2*)
   ❒ Other, please specify. _____ (*If checked, go to 2*)
2. Is the patient currently receiving treatment with the requested drug?
   ❒ Yes, *Continue to 3*
   ❒ No, *Continue to 4*
3. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
   ❒ Yes, *No Further Questions*
   ❒ No, *No Further Questions*
4. What is the clinical setting in which the requested drug will be used?
   ❒ Recurrent unresectable (*If checked, go to 5*)
   ❒ Metastatic disease (*If checked, go to 5*)
   ❒ The disease had no response to preoperative systemic therapy (*If checked, go to 5*)
   ❒ Other, please specify. _____ (*If checked, go to 5*)
5. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Attach supporting chart note(s) or test results for human epidermal growth factor receptor 2 (HER2) status.
   ❒ HER2 positive (*If checked, go to 6*)
   ❒ HER2 negative (*If checked, go to 6*)
   ❒ Unknown (*If checked, go to 6*)

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6. Will the requested drug be used in combination with chemotherapy?
   - ❒ Yes, *Continue to 7*
   - ❒ No, *Continue to 7*
7. Has the patient received treatment with two or more regimens?
   - ❒ Yes, *No Further Questions*
   - ❒ No, *No Further Questions*

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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