Phesgo

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:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** _____________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

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. Phesgo SGM – 5/2021.

Criteria Questions:

1. What is the diagnosis?
   ❑ Breast cancer
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. In what clinical setting is Phesgo being used?
   ❑ Neoadjuvant (pre-operative) treatment of breast cancer
   ❑ Adjuvant treatment of breast cancer
   ❑ Treatment of recurrent or metastatic breast cancer
   ❑ Other _______________________________
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #8*
5. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
6. How many months of Phesgo treatment has the patient received? ____________ months
7. Has the patient received Phesgo for 12 months (52 weeks) or greater? ❑ Yes ❑ No *No further questions*
8. 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. ❑ Positive ❑ Negative ❑ Unknown
9. *If Phesgo will be used as neoadjuvant (pre-operative) treatment of breast cancer,* is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)? ❑ Yes ❑ No
10. *If Phesgo will be used as adjuvant treatment of breast cancer,* is the disease either node-positive or at high risk for recurrence? ❑ Yes ❑ No
11. Will Phesgo be used in combination with chemotherapy? ❑ 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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