Retevmo

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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Non-small cell lung cancer
   - ❑ Erdheim-Chester Disease (ECD)
   - ❑ Medullary thyroid cancer
   - ❑ Rosai-Dorfman Disease (RDD)
   - ❑ Anaplastic thyroid cancer
   - ❑ Langerhans Cell Histiocytosis (LCH)
   - ❑ Thyroid cancer
   - ❑ Solid tumors
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
5. *If diagnosis is Non-small cell lung cancer, Medullary thyroid cancer Thyroid cancer, or Solid Tumors*, how is the patient's disease classified?
   - ❑ Recurrent disease
   - ❑ Advanced disease
   - ❑ Metastatic disease
   - ❑ Other _____

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

Section A: Non-Small Cell Lung Cancer

6. Will the requested medication be used as a single agent? ❑ Yes ❑ No
7. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

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

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. Retevmo SGM - 11/2022.

Section B: Medullary Thyroid Cancer

8. Does the patient have a rearranged during transfection (*RET)* gene mutation? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene mutation.*** ❑ Yes ❑ No ❑ Unknown

Section C: Anaplastic Thyroid Cancer

9. Will the requested medication be used as a single agent? ❑ Yes ❑ No *If No, skip to Section D*

10. What is the place in therapy in which the requested medication be used?
❑ Neoadjuvant therapy ❑ Other _____, *skip to Section D*

11. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

Section D: Thyroid Cancer

12. Is the patient refractory to treatment with radioactive iodine? *If Yes, skip to #14* ❑ Yes ❑ No

13. Is radioactive iodine an appropriate treatment for the patient? ❑ Yes ❑ No

14. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

Section E: Solid Tumors

15. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

16. Has the disease progressed on or following prior systemic treatment? *If Yes, no further questions.* ❑ Yes ❑ No

17. Does the patient have no satisfactory alternative treatment options? ❑ Yes ❑ No

Section E: Erdheim-Chester Disease (ECD) or Rosai-Dorfman Disease (RDD)

18. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

19. Will the requested medication be used as a single agent? ❑ Yes ❑ No

20. Does the patient have symptomatic disease? *If Yes, no further questions.* ❑ Yes ❑ No

21. Does the patient have relapsed or refractory disease? ❑ Yes ❑ No

Section F: Langerhans Cell Histiocytosis (LCH)

22. Does the patient have a rearranged during transfection (*RET)* gene fusion? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results for RET gene fusion.*** ❑ Yes ❑ No ❑ Unknown

23. Will the requested medication be used as a single agent? ❑ 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

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. Retevmo SGM - 11/2022.