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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:** _____

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*

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the patient's diagnosis?

❒ Neutropenia associated with myelosuppressive anti-cancer therapy, *Continue to #10*

❒ Stem cell transplantation-related indication, *No Further Questions*

❒ Hematopoietic acute radiation syndrome, *Continue to #2*

❒ Hairy cell leukemia, *Continue to #3*

❒ Other, *No Further Questons*

Hematopoietic subsyndrome of acute radiation syndrome

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2. Will the requested medication be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?

❒ Yes, *No Further Questions*

❒ No, No Further *Questions*

Hairy cell leukemia

3. Will the requested medication be used for treatment of neutropenic fever following chemotherapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Neutropenia in cancer patients receiving myelosuppressive chemotherapy

10. Will the requested medication be used in combination with any other colony stimulating factor products within any chemotherapy cycle?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Will the patient be receiving chemotherapy and radiation therapy at the same time?

❒ Yes, *Continue to #12*

❒ No, *Continue to #12*

12. Will the requested medication be administered with a weekly chemotherapy regimen?

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

13. For which of the following indications is the requested medication being prescribed?
❒ Primary prophylaxis (i.e., to be given 24 hours after first cycle of chemotherapy) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *Continue to #14*
❒ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancies, *Continue to #17*

❒ Other, *No Further Questions*

Primary prophylaxis

14. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 20% or higher incidence of febrile neutropenia? ***ACTION REQUIRED****: If yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen*

❒ Yes, *No Further Questions*

❒ No, *Continue to #15*

15. Has the patient received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-19% incidence of febrile neutropenia? ***ACTION REQUIRED****: If yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen.*

❒ Yes, *Continue to #16*

❒ No, *Continue to #16*

16. Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise or co-morbidity, including any of the following? ***ACTION REQUIRED****: If yes, please submit documentation confirming the patient's risk factors*

- Active infections, open wounds, or recent surgery
- Age greater than or equal to 65 years
- Bone marrow involvement by tumor producing cytopenias
- Previous chemotherapy or radiation therapy
- Poor nutritional status
- Poor performance status
- Previous episodes of FN
- Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease
- Persistent neutropenia

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Secondary prophylaxis

17. Has the patient experienced a febrile neutropenic complication or a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?

❒ Yes, *Continue to #18*

❒ No, *Continue to #18*

18. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)?

❒ 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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720