Jemperli

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*

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

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is this request to continue previously established treatment with the requested medication?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested medication). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested medication for 6 months). *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested medication for 7 months or greater – initial 6 months plus 45 days grace period).

C. Is the patient receiving provider administered combination chemotherapy? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Endometrial Cancer (EC), *Continue to #2*
   - ❑ Solid Tumors, *Continue to #2*
   - ❑ Breast Cancer, *Continue to #2*
   - ❑ Colorectal Cancer, including appendiceal adenocarcinoma, *Continue to #2*
   - ❑ Esophageal, Esophagogastric Junction and Gastric Cancer, *Continue to #2*
   - ❑ Occult Primary Cancer, *Continue to #2*
   - ❑ Ovarian cancer, *Continue to #2*
   - ❑ Small Bowel Adenocarcinoma, *Continue to #2*
   - ❑ Ampullary adenocarcinoma, *Continue to #2*
   - ❑ Other, *Continue to #2*

2. Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo, Keytruda)?
   - ❑ Yes, *Continue to #3*
   - ❑ No, *Continue to #3*

3. Is the request for continuation of therapy?
   - ❑ Yes, *Continue to #4*
   - ❑ No, *Continue to #10*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   - ❑ Yes, *No Further Questions*
   - ❑ No, *No Further Questions*

10. What is the diagnosis?
    - ❑ Endometrial Cancer (EC), *Continue to #20*
    - ❑ Solid Tumors, *Continue to #30*
    - ❑ Breast Cancer, *Continue to #40*
    - ❑ Colorectal Cancer, including appendiceal adenocarcinoma, *Continue to #50*
    - ❑ Esophageal, Esophagogastric Junction and Gastric Cancer, *Continue to #60*
    - ❑ Occult Primary Cancer, *Continue to #70*
    - ❑ Ovarian cancer, *Continue to #80*
    - ❑ Small Bowel Adenocarcinoma, *Continue to #90*
    - ❑ Ampullary adenocarcinoma, *Continue to #95*

20. In which clinical setting will the requested drug be used?
    - ❑ Recurrent disease, *Continue to #21*
    - ❑ Advanced disease, *Continue to #21*
    - ❑ Other, *Continue to #21*

21. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high (MSI-H) or mismatch repair deficient tumor status
    - ❑ Yes, *Continue to #22*
    - ❑ No, *Continue to #22*
    - ❑ Unknown, *Continue to #22*

22. Has the disease progressed on or following prior treatment with a platinum-containing regimen (e.g., cisplatin,
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*

30. In which clinical setting will the requested drug be used?
    - ❑ Recurrent disease, *Continue to #31*
    - ❑ Advanced disease, *Continue to #31*
    - ❑ Other, *Continue to #31*

31. Is the tumor mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming mismatch repair deficient tumor status
    - ❑ Yes, *Continue to #32*
    - ❑ No, *Continue to #32*
    - ❑ Unknown, *Continue to #32*

32. Will the requested drug be used as a single agent?
    - ❑ Yes, *Continue to #33*
    - ❑ No, *Continue to #33*

33. Has the patient experienced disease progression following prior treatment?
    - ❑ Yes, *Continue to #34*
    - ❑ No, *Continue to #34*

34. Are there other satisfactory alternative treatment options available for the patient?
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*

40. What is the clinical setting in which the requested drug will be used?
    - ❑ Recurrent unresectable disease, *Continue to #41*
    - ❑ Stage IV disease, *Continue to #41*
    - ❑ Other, *Continue to #41*

41. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high (MSI-H) or mismatch repair deficient tumor status.
    - ❑ Yes, *Continue to #42*
    - ❑ No, *Continue to #42*
    - ❑ Unknown, *Continue to #42*

42. Has the disease progressed on or following prior treatment?
    - ❑ Yes, *Continue to #43*
    - ❑ No, *Continue to #43*

43. Are there other satisfactory alternative treatment options available for the patient?
    - ❑ Yes, *Continue to #44*
    - ❑ No, *Continue to #44*

44. Will the requested drug be used as a single agent?
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*

50. What is the clinical setting in which the requested drug will be used?
    - ❑ Advanced disease, *Continue to #51*
    - ❑ Metastatic disease, *Continue to #51*
    - ❑ Other, *Continue to #51*

51. What is the place in therapy in which the requested drug will be used?
    - ❑ First-line treatment, *Continue to #52*
    - ❑ Subsequent treatment, *Continue to #52*

52. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required:*** If 'Yes', attach laboratory report confirming microsatellite instability-high (MSI-H) or mismatch repair deficient tumor status.
    - ❑ Yes, *Continue to #53*
    - ❑ No, *Continue to #53*
    - ❑ Unknown, *Continue to #53*

53. Has the patient received previous oxaliplatin- irinotecan- and/or fluoropyrimidine-based (e.g., fluorouracil,
    - ❑ Yes, *Continue to #54*
    - ❑ No, *Continue to #54*

54. Will the requested drug be used as a single agent?
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*

60. Will the requested drug be used as a single agent?
    - ❑ Yes, *Continue to #61*
    - ❑ No, Continue to #61

61. What is the clinical setting in which the requested drug will be used?
    - ❑ Unresectable locally advanced disease, *Continue to #62*
    - ❑ Recurrent disease, *Continue to #62*
    - ❑ Metastatic disease, *Continue to #62*

❑ The patient is not a surgical candidate, *Continue to #62*
❑ Other, *Continue to #62*

62. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high (MSI-H) or mismatch repair deficient tumor status.
❑ Yes, *Continue to #63*
❑ No, *Continue to #63*
❑ Unknown, *Continue to #63*

63. Has the disease progressed on or following prior treatment?
❑ Yes, *Continue to #64*
❑ No, *Continue to #64*

64. Are there other satisfactory alternative treatment options available for the patient?
❑ Yes, *Continue to #65*
❑ No, *Continue to #65*

65. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment, *Continue to #66*
❑ Subsequent treatment, *Continue to #66*

66. Will the requested drug be used as palliative therapy?
❑ Yes, *No Further Questions*
❑ No, *No Further Questions*

70. Will the requested drug be used as a single agent?
❑ Yes, *Continue to #71*
❑ No, *Continue to #71*

71. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high (MSI-H) or mismatch repair deficient tumor status.
❑ Yes, *No Further Questions*
❑ No, *No Further Questions*
❑ Unknown, *No Further Questions*

80. Which of the following applies to the patient's disease?
❑ Epithelial ovarian cancer, *Continue to #81*
❑ Fallopian tube cancer, *Continue to #81*
❑ Primary peritoneal cancer, *Continue to #81*
❑ Carcinosarcoma (malignant mixed Mullerian tumors), *Continue to #81*
❑ Clear cell carcinoma, *Continue to #81*
❑ Mucinous carcinoma, *Continue to #81*
❑ Grade 1 endometrioid carcinoma, *Continue to #81*
❑ Low-grade serous carcinoma/ovarian borderline epithelial tumors, *Continue to #81*
❑ Other, *Continue to #81*

81. Will the requested drug be used as a single agent?
❑ Yes, *Continue to #82*
❑ No, *Continue to #82*

82. What is the clinical setting in which the requested drug will be used?
❑ Recurrent disease, *Continue to #83*
❑ Persistent disease, *Continue to #83*
❑ Advanced disease, *Continue to #83*
❑ Other, *Continue to #83*

83. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*
    - ❑ Unknown, *No Further Questions*

90. Will the requested drug be used as a single agent?
    - ❑ Yes, *Continue to #91*
    - ❑ No, *Continue to #91*

91. What is the clinical setting in which the requested drug will be used?
    - ❑ Advanced disease, *Continue to #92*
    - ❑ Metastatic disease, *Continue to #92*
    - ❑ Other, *Continue to #92*

92. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*
    - ❑ Unknown, *No Further Questions*

95. Will the requested drug be used as a single agent?
    - ❑ Yes, *Continue to #96*
    - ❑ No, *Continue to #96*

96. What is the clinical setting in which the requested drug will be used?
    - ❑ Recurrent disease, *Continue to #97*
    - ❑ Advanced disease, *Continue to #97*
    - ❑ Other, *Continue to #97*

97. What is the place in therapy in which the requested drug will be used?
    - ❑ First-line treatment, *Continue to #98*
    - ❑ Subsequent treatment, *Continue to #98*

98. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***Action required***: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status.
    - ❑ Yes, *No Further Questions*
    - ❑ No, *No Further Questions*
    - ❑ Unknown, *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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com