Abraxane (for Maryland only)

Prior Authorization Request

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

CVS Caremark administers the prescription benefit plan for the member 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 **1-866-814-5506.** 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.

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

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Breast cancer
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Pancreatic adenocarcinoma
   - ❑ Melanoma
   - ❑ Epithelial ovarian cancer
   - ❑ Fallopian tube cancer
   - ❑ Primary peritoneal cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

5. Is the medication effective in treating the member's condition?
   ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

6. How is the patient's disease classified?
   Indicate all that apply
   - ❑ Recurrent disease
   - ❑ Locally advanced disease
   - ❑ Persistent disease
   - ❑ Metastatic disease
   - ❑ Unresectable disease
   - ❑ Other _____

7. In which clinical setting will Abraxane be used?
   - ❑ As first line therapy
   - ❑ As second line therapy
   - ❑ As subsequent therapy
   - ❑ As neoadjuvant therapy
   - ❑ Other _____

8. How will Abraxane be used (i.e. single agent, in combination with Gemzar)?
   _____***Complete the following questions based on the patient's diagnosis.***

Section A: Non-Small Cell Lung Cancer (NSCLC)

9. Is Abraxane being substituted for docetaxel or paclitaxel? ❑ Yes ❑ No

10. Has the patient experienced a hypersensitivity reaction after receiving docetaxel or paclitaxel despite premedication?
    If Yes, no further questions ❑ Yes ❑ No

11. Are standard hypersensitivity premedications contraindicated for the patient?
    If Yes, no further questions ❑ Yes ❑ No

12. *If clinical setting is subsequent therapy*, does the patient have any of the following tumor mutations?
    ❑ sensitizing epidermal growth factor receptor (EGFR)-positive
    ❑ anaplastic lymphoma kinase (ALK)-positive, *skip to #14*
    ❑ None of the above

13. Has the patient received prior EGFR inhibitor therapy [e.g., erlotinib (Tarceva), afatinib (Gilotrif), gefitinib (Iressa)]? *If Yes, no further questions* ❑ Yes ❑ No

14. Has the patient received prior ALK inhibitor therapy [e.g., crizotinib (Xalkori)]? ❑ Yes ❑ No

Section B: Melanoma

15. Will Abraxane be used for disease progression after prior systemic therapy? ❑ 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)**