Alimta (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 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 **1-866-814-5506.** 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?
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Upper genitourinary tract tumor
   - ❑ Malignant pleural mesothelioma
   - ❑ Urothelial carcinoma of the prostate
   - ❑ Bladder cancer
   - ❑ Fallopian tube cancer
   - ❑ Ovarian cancer (epithelial)
   - ❑ Primary peritoneal cancer
   - ❑ Primary CNS lymphoma
   - ❑ Thymoma/thymic carcinoma
   - ❑ Primary carcinoma of the urethra
   - ❑ 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. Will Alimta be used as a single agent (monotherapy)? ❑ Yes ❑ No
   If No, what is the chemotherapy regimen? _____

Complete the following section based on the member's diagnosis.

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

7. Does the patient have the squamous type of NSCLC? ❑ Yes ❑ No

8. What is the intent of treatment with Alimta?
   - ❑ Preoperative chemoradiation, *no further questions*
   - ❑ Neoadjuvant or induction chemotherapy, *no further questions*
   - ❑ Initial treatment as definitive chemoradiation, *no further questions*
   - ❑ Adjuvant chemotherapy, *no further questions*
   - ❑ Adjuvant chemoradiation, *no further questions*
   - ❑ Chemoradiation for locoregional recurrence, *no further questions*
   - ❑ Chemotherapy for recurrent, locally advanced or metastatic disease
   - ❑ Other _____

9. In which clinical setting will Alimta be used?
   - ❑ Initial or first-line therapy, *no further questions*
   - ❑ Maintenance therapy following first-line therapy, *continue to #10*
   - ❑ Subsequent therapy (eg, second-line therapy), *skip to #11*
   - ❑ Other _____

NSCLC - Maintenance Therapy Questions

10. Was tumor response or stable disease achieved with the first-line chemotherapy regimen? ❑ Yes ❑ No

NSCLC - Subsequent Therapy Questions

11. For which of the following will Alimta be used?
    - ❑ Disease progression following first-line cytotoxic chemotherapy, *no further questions*
    - ❑ For further progression on a systemic immune checkpoint inhibitor (e.g., nivolumab, pembrolizumab) or other systemic therapy, *no further questions*
    - ❑ None of the above

12. Will Alimta be used following prior epidermal growth factor receptor (EGFR) inhibitor therapy (eg, erlotinib, afatinib, gefitinib)? ❑ Yes ❑ No *If No, skip to #14*

13. Does the member have a sensitizing EGFR mutation-positive tumor?
    - ❑ Yes
    - ❑ No
    - ❑ Unknown *No further questions*

14. Will Alimta be used following prior anaplastic lymphoma kinase (ALK) inhibitor therapy (eg, crizotinib)?
    ❑ Yes ❑ No

15. Does the member have an ALK mutation-positive tumor? ❑ Yes ❑ No ❑ Unknown

Section B: Malignant Pleural Mesothelioma

16. Is Alimta prescribed as induction therapy or first-line chemotherapy?
    - ❑ Yes, *no further questions*
    - ❑ No

17. Is Alimta prescribed as second-line chemotherapy? ❑ Yes ❑ No

Section C: Bladder Cancer

18. Is Alimta prescribed as second-line therapy for locally advanced, post cystectomy-recurrent, or metastatic disease?
    ❑ Yes ❑ No

Section D: Primary Carcinoma of the Urethra, Upper Genitourinary Tract Tumors, and Urothelial Carcinoma of the Prostate

19. Is Alimta prescribed as second-line therapy for recurrent or metastatic disease? ❑ Yes ❑ No

Section E: Ovarian Cancer (Epithelial), Fallopian Tube Cancer, and Primary Peritoneal Cancer

20. Does the patient have persistent or recurrent disease? ❑ Yes ❑ No

Section F: Primary CNS Lymphoma

21. Does the patient have recurrent or progressive disease? ❑ Yes ❑ No

Section G: Thymoma/Thymic Carcinoma

22. Will Alimta be used as second-line 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)**