Gilotrif

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.

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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?
   ❑ Recurrent, advanced or metastatic non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC)
   ❑ Non-nasopharyngeal head and neck cancer
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. Is the patient currently receiving treatment with Gilotrif? ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Has the patient experienced an unacceptable toxicity from treatment with Gilotrif?
   ❑ Yes ❑ No *No further questions*

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

Section A: Non-Small Cell Lung Cancer (NSCLC) (Including Brain Metastases from NSCLC)

5. Is Gilotrif requested for treatment of metastatic squamous non-small cell lung cancer (NSCLC) progressing after platinum-based chemotherapy? *If Yes, no further questions.* ❑ Yes ❑ No
6. Does the patient have a sensitizing epidermal growth factor receptor (EGFR) mutation? ***ACTION REQUIRED: If Yes, attach test result demonstrating a sensitizing EGFR mutation.*** ❑ Yes ❑ No ❑ Unknown

Section B: Non-Nasopharyngeal Head and Neck Cancer

7. Has the patient's disease progressed on or after platinum-containing chemotherapy? ❑ 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

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