CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Provenge (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 prescribed medication? ❑ Provenge ❑ Other _____
2. What is the diagnosis? ***Action Required: Please attach current oncology notes, clinical notes that include the history of previous treatments (including previous hormone therapy), and any pertinent pathology reports and/or imaging studies (e.g., demonstrating metastatic disease).***
   ❑ Prostate cancer
   ❑ Other _____
3. What is the ICD code? _____
4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #7*
5. 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.)***
6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #7 and complete this form in its entirety.*
7. What is the specialty of the practitioner who recommended Provenge?
   ❑ Oncologist
   ❑ Urologist
   ❑ Other _____
8. What is the stage of prostate cancer? ***Action Required: Please attach documentation of prostate cancer stage.***
   ❑ Clinically localized ❑ Metastatic
   ❑ Locally advanced ❑ Other _____
9. Is the disease resistant to hormonal therapy (i.e., castration-resistant)? ❑ Yes ❑ No
   Action Required: Please attach documentation of previous hormone therapy.

10. Does the patient experience symptoms from the disease? ❑ Yes ❑ No *If No, skip to #12*

11. Is the patient minimally symptomatic? ❑ Yes ❑ No

12. What is the patient's Eastern Cooperative Oncology Group (ECOG) performance status (PS)?
    ❑ PS 0 ❑ PS 1
    ❑ PS 2 ❑ PS 3
    ❑ S 4 ❑ Other _____

13. What is the patient's life expectancy? _____ months

14. Does the patient have hepatic metastases? ❑ Yes ❑ No

15. Has the patient received Provenge previously? ❑ 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)**