CareFirst BlueCross BlueShield
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Tarceva (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-866-249-6155

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.

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.

1. What is the patient's diagnosis?
   - ❑ Non-small cell lung cancer
   - ❑ Pancreatic cancer
   - ❑ Chordoma
   - ❑ Renal cell carcinoma
   - ❑ 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? Please check all that apply.
   ❑ Locally advanced ❑ Advanced ❑ Metastatic ❑ Recurrent ❑ None of the above
7. What is the prescribed regimen?
   - ❑ Single agent (Tarceva only)
   - ❑ Tarceva + gemcitabine (Gemzar)
   - ❑ Tarceva in combination with chemotherapy
   - ❑ Other _____

Complete the following section based on the patient's diagnosis

<u>Section A: Non-Small Cell Lung Cancer</u>

8. Does the patient have epidermal growth factor receptor (EGFR) mutation positive disease?
   ❑ Yes ❑ No ❑ Unknown *If No or Unknown, skip to 11.*
   ACTION REQUIRED: EGFR test results MUST be attached to this PA in order to make a final determination.
9. What is the patient's EGFR mutation status?
   ❑ Positive for exon 19 deletion ❑ Positive for exon 21 L858R substitution ❑ Other _____

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10. What is the intent of treatment?
    ❑ First-line therapy for locally advanced, recurrent, or metastatic disease (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy)
    ❑ Subsequent therapy

11. Is Tarceva being requested for use as subsequent therapy following progression on a cytotoxic regimen?
    ❑ Yes ❑ No

12. Has the patient previously received and progressed on therapy with erlotinib? ❑ Yes ❑ No

Section B: Pancreatic Cancer

13. Does the patient have locally advanced unresectable or metastatic disease? ❑ Yes ❑ No

Section C: Renal Cell Carcinoma

14. Is Tarceva being requested for the treatment of relapsed or medically unresectable stage IV disease? ❑ Yes ❑ No

15. Does the disease express non-clear cell histology? ❑ 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)**