Docetaxel

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ______________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** __________________________________
Specialty: ___________________________________ **HPHC Provider ID**______________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

Rendering Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**____________________
Name: ____ **NPI#:** ________________________________
Fax: ____________________ **Phone:** __________________ **Provider Tax ID:** ________________________

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

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*
Pharmacy

Drug Information:

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Docetaxel Medical – 01/2019.

Criteria Questions:

1. What is the prescribed medication?
   ❑ Taxotere (docetaxel) ❑ Docefrez (docetaxel) ❑ docetaxel (generic) ❑ Other ______________________
2. What is the patient's diagnosis?
   ❑ Breast cancer
   ❑ Prostate cancer
   ❑ Non-small cell lung cancer (NSCLC)
   ❑ Gastric cancer
   ❑ Esophageal and esophagogastric junction cancer
   ❑ Ovarian cancer (epithelial)
   ❑ Fallopian tube cancer
   ❑ Primary peritoneal cancer
   ❑ Malignant sex-cord stromal tumor (ovarian cancer)
   ❑ Malignant germ cell tumor (ovarian cancer)
   ❑ Carcinosarcoma (Malignant mixed Müllerian tumors)
   ❑ Clear cell carcinoma
   ❑ Mucinous carcinoma
   ❑ Low-grade Serous/Grade 1 endometrioid epithelial carcinoma
   ❑ Recurrent or metastatic urothelial carcinoma of the prostate
   ❑ Recurrent or metastatic upper genitourinary tract tumor
   ❑ Recurrent or metastatic primary carcinoma of the urethra
   ❑ Metastatic, relapsed or progressive Ewing's sarcoma
   ❑ Relapsed/refractory or metastatic osteosarcoma
   ❑ Soft tissue sarcoma
   ❑ Head and neck cancer
   ❑ Bladder cancer
   ❑ Small cell lung cancer
   ❑ Thyroid carcinoma (anaplastic carcinoma)
   ❑ Occult primary (cancer of unknown primary)
   ❑ Endometrial carcinoma
   ❑ Uterine sarcoma
   ❑ Other ____
3. What is the ICD-10 code? ________________

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)**

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

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