



2211 Sanders Road, Northbrook, IL 60062 Phone (844) 387-1435

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (844) 851-0882

Re: Prior Authorization for {Auth.Member.MemberNameFirst}

{Auth.Member.MemberNameLast}

Phone (10-15 minutes process time)	Fax (24-72 hours process time)
Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. 1-844-387-1435	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. 1-844-851-0882

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}



Herceptin

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 Name: {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

Date: {System.DateTime.Today}

Patient's ID: {Auth.Member.MemberID}

Patient's Date of Birth:
{Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}

NPI#: {Auth.ProviderBilling.NPI}

Specialty: _____

HPHC Provider ID: _____

Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

Physician Office Fax:

{Auth.OfficeContactFaxNumber}

Provider Tax ID: _____

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

Drug Information:

Strength/Measure _____ **Units** ml Gm mg ea Un

Directions(sig) _____ **Route of administration** _____

Dosing frequency _____

Criteria Questions:

- What is the patient's diagnosis?
 Esophageal, gastric or gastroesophageal junction cancer
 Leptomeningeal metastases from breast cancer
 Breast cancer
 Other _____
- What is the ICD-10 code? _____
- What is the HER2 status of the disease?
 HER2 positive
 HER2 negative
 Unknown

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. Herceptin SGM - 06/2018.

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Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Complete the following questions if patient has Breast cancer.

4. In which clinical setting will Herceptin be used?
- Preoperative/neoadjuvant treatment
 - Adjuvant treatment
 - Treatment of recurrent or metastatic disease
 - Other _____
5. *If clinical setting is adjuvant treatment*, has the patient received Herceptin for 12 months (52 weeks) or greater as adjuvant therapy? Yes No N/A

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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