# Zoladex

## 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**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____ **HPHC Provider 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:**
1. What is the diagnosis?
   - ❑ Prostate cancer
   - ❑ Breast cancer
   - ❑ Dysfunctional uterine bleeding (3.6 mg dose only)
   - ❑ Endometriosis (3.6 mg dose only)
   - ❑ Gender dysphoria
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What dose of Zoladex is being prescribed? ❑ Zoladex 3.6 mg ❑ Zoladex 10.8 mg

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

Section A: Breast Cancer
4. What is the patient's hormone receptor (HR) status? ❑ Positive ❑ Negative ❑ Unknown

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



**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com**

Section B: Dysfunctional Uterine Bleeding (3.6 mg dose only)

5. Will Zoladex be used as an endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding? ❑ Yes ❑ No

Section C: Endometriosis (3.6 mg dose only)

6. For how many months has the patient already received Zoladex for this indication? _____ months

Section D: Gender Dysphoria

7. What is the patient's physical developmental stage?
   ❑ Patient has NOT completed puberty
   ❑ Patient has completed puberty, *skip to #10*

8. Is Zoladex prescribed for pubertal suppression in preparation for gender reassignment? ❑ Yes ❑ No

9. Which Tanner Stage of puberty has the patient reached?
   ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ Unknown *No further questions*

10. Is the patient undergoing gender reassignment? ❑ Yes ❑ No

11. Will the patient receive Zoladex concomitantly with cross sex hormones? ❑ 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)**

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