Trueqap (capivasertib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

Trueqap (capivasertib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Breast cancer ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No

Does patient have a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer? ☐ Yes ☐ No *Please submit documentation*.

Is the HR-positive, HER2 negative breast cancer locally advanced or metastatic? ☐ Yes ☐ No *Please submit documentation*.

Does the HR-positive, HER2 negative breast cancer contain 1 or more PIK3CA/AKT1/PTEN-alterations? ☐ Yes ☐ No *Please submit documentation*.

Did patient have progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy? ☐ Yes ☐ No *Please submit documentation*.

Will patient use concomitant treatment with LHRH agonist such as leuprolide(Lupron), goserelin(Zoladex), triptorelin(Trelstar, or histrelin(Vantas)? ☐ Yes ☐ No *Please submit documentation*.

Does patient have an ECOG score of 0-1? ☐ Yes ☐ No

Has patient received prior treatment with an aromatase inhibitor(AI) such as anastrozole (Arimidex), exemestane (Aromasin), or letrozole (Femara) containing regimen (single agent or in combination)? ☐ Yes ☐ No *Please submit documentation*.

Does patient have radiological evidence of breast cancer recurrence or progression while on, or within 12 months of the end of (neo)adjuvant treatment with an aromatase inhibitor? ☐ Yes ☐ No *Please submit documentation*.

Does patient have radiological evidence of progression while on prior aromatase inhibitor administered as a treatment line for locally advanced or metastatic breast cancer (this does not need to be the most recent therapy)? ☐ Yes ☐ No *Please submit documentation*.

Trueqap (capivasertib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Has patient had more than 2 lines of endocrine therapy for inoperable locally advanced or metastatic disease? □ **Yes** □ **No** ***Please submit documentation*.**

Has patient had more than 1 line of chemotherapy for inoperable locally advanced or metastatic disease? □ **Yes** □ **No** ***Please submit documentation*.**

Has patient had prior treatment with any of the following fulvestrant: tamoxifen, raloxifene, and toremifene? □ **Yes** □ **No** ***Please submit documentation*.**

Has patient had prior treatment with any of the following: an AKT, PI3K and/or mTOR inhibitors such as Trueqap(capivasertib), Piqray(apelisib), Afinitor(everolimus)? □ **Yes** □ **No** ***Please submit documentation*.**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program Attn:CP-4201
P.O.Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909