Prescriber Criteria Form Piqray 2025 PA Fax 3090-A v1 010125.docx Piqray (alpelisib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Piqray (alpelisib).

Drug Name: Piqray (alpelisib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient have hormone receptor (HR)-positive breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient have phosphatidylinositol-3-kinase catalytic alpha subunit (PIK3CA)-mutated breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
6	Will the requested drug be used in combination with fulvestrant?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____