Prescriber Criteria Form

Toremifene 2025 PA Fax 3628-A v1 010125.docx
Fareston (toremifene citrate)
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 Fareston (toremifene citrate).

Drug Name:
Fareston (toremifene citrate)

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	Is the requested drug being prescribed for the treatment of metastatic breast cancer in a postmenopausal patient with estrogen-receptor positive or unknown tumor? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have ANY of the following: A) congenital or acquired QT prolongation (long QT syndrome), B) uncorrected hypokalemia, C) uncorrected hypomagnesemia?	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:**_____