

Prescriber Criteria Form

Truqap 2025 PA Fax 6266-A v1 010125.docx  
 Truqap (capivasertib)  
 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 Truqap (capivasertib).

Drug Name:  
 Truqap (capivasertib)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

<b>Please circle the appropriate answer for each question.</b>			
1	Does the patient have a diagnosis of breast cancer? [If no, then no further questions.]	Yes	No
2	Is the requested drug being used in combination with fulvestrant? [If no, then no further questions.]	Yes	No
3	Does the patient's disease meet all of the following: A) hormone receptor (HR)-positive, B) human epidermal growth factor receptor 2 (HER2)-negative? [If no, then no further questions.]	Yes	No
4	Is the patient's disease locally advanced or metastatic? [If no, then no further questions.]	Yes	No
5	Does the patient's disease possess one or more PIK3CA/AKT/PTEN-alteration? [If no, then no further questions.]	Yes	No
6	Does the patient meet one of the following: A) progression on at least one endocrine-based regimen in the metastatic setting, B) has the patient experienced recurrence on or within 12 months of completing adjuvant therapy?	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:** \_\_\_\_\_