Prescriber Criteria Form Orserdu 2024 PA Fax 5776-A v1 010124.docx Orserdu (elacestrant) 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 Orserdu (elacestrant).

Drug Name: Orserdu (elacestrant)

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	Does the patient's disease meet all of the following: A) estrogen receptor (ER) positive, B) human epidermal growth factor receptor 2 (HER2)-negative, AND C) ESR1 mutated? [If no, then no further questions.]	Yes	No
3	Is the patient's disease advanced, recurrent, or metastatic? [If no, then skip to question 5.]	Yes	No
4	Has the patient experienced disease progression following at least one line of endocrine therapy? [No further questions.]	Yes	No
5	Has the disease had a response to preoperative systemic 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:_____