

Prescriber Criteria Form

Firmagon 2024 PA Fax 3873-A v1 010124.docx  
Firmagon (degarelix)  
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 Firmagon (degarelix).

Drug Name:  
Firmagon (degarelix)

|                            |                        |             |
|----------------------------|------------------------|-------------|
| <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>    |             |

**Please circle the appropriate answer for each question.**

|   |   |     |    |
|---|---|-----|----|
| 1 | Does the patient have a diagnosis of prostate cancer? | 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:** \_\_\_\_\_