Prescriber Criteria Form Rubraca 2024 PA Fax 1569-A v2 010124.docx Rubraca (rucaparib) 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 Rubraca (rucaparib).

Drug Name: Rubraca (rucaparib)

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 epithelial ovarian, fallopian tube, or primary peritoneal cancer? [If no, then skip to question 7.]	Yes	No
2	Is the requested drug being used for maintenance treatment? [If no, then no further questions.]	Yes	No
3	Does the patient have recurrent disease? [If no, then skip to question 5.]	Yes	No
4	Is the patient in a complete or partial response to platinum-based chemotherapy? [No further questions.]	Yes	No
5	Does the patient have advanced (stage II-IV) disease? [If no, then no further questions.]	Yes	No
6	Is the patient in a complete or partial response to primary therapy? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of metastatic castration-resistant prostate cancer? [If no, then skip to question 11.]	Yes	No
8	Has the patient been treated with androgen receptor-directed therapy?	Yes	No

	[If no, then no further questions.]		
9	Does the patient meet either of the following criteria: A) patient has been treated with taxane-based chemotherapy, B) patient is not fit for chemotherapy? [If no, then no further questions.]	Yes	No
10	Will the requested drug be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of uterine leiomyosarcoma? [If no, then skip to question 14.]	Yes	No
12	Is the requested drug being used as second line-therapy? [If no, then no further questions.]	Yes	No
13	Does the patient have BRCA (breast cancer susceptibility gene) -altered disease? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of metastatic pancreatic adenocarcinoma? [If no, then no further questions.]	Yes	No
15	Does the disease have somatic or germline BRCA (breast cancer susceptibility gene) or PALB-2 (partner and localizer of BRCA-2) mutations?	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:**_____