Prescriber Criteria Form

Itovebi 2026 PA Fax 6698-A v3 010126.docx
Itovebi (inavolisib)
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 Itovebi (inavolisib).

Drug Name:
Itovebi (inavolisib)

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 used for the treatment of breast cancer? [If no, then no further questions.]	Yes	No
2	Is the disease recurrent, locally advanced, or metastatic? [If no, then no further questions.]	Yes	No
3	Does the patient have hormone receptor (HR)-positive breast cancer? [If no, then no further questions.]	Yes	No
4	Does the patient have human epidermal growth factor receptor 2 (HER2)-negative breast cancer? [If no, then no further questions.]	Yes	No
5	Does the patient have phosphatidylinositol-3-kinase catalytic alpha subunit (PIK3CA)-mutated breast cancer? [If no, then no further questions.]	Yes	No
6	Has the patient experienced disease progression, relapse, or recurrence on or after completing adjuvant endocrine therapy? [If no, then no further questions.]	Yes	No
7	Will the requested drug be used in combination with palbociclib and fulvestrant?	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:_____