Prescriber Criteria Form Lynparza 2026 PA Fax 1232-A v3 010126.docx Lynparza (olaparib) 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 Lynparza (olaparib).

Drug Name: Lynparza (olaparib)

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 ovarian, fallopian tube, or primary peritoneal cancer? [If no, then skip to question 4.]	Yes	No
2	Is the requested drug being used for maintenance therapy for stage II-IV or recurrent disease? [If no, then no further questions.]	Yes	No
3	Is the request for a patient who is in complete or partial response to chemotherapy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of recurrent or metastatic breast cancer? [If yes, then skip to question 8.]	Yes	No
5	Does the patient have a diagnosis of high-risk early breast cancer? [If no, then skip to question 9.]	Yes	No
6	Is the requested drug being used as adjuvant treatment following neoadjuvant or adjuvant chemotherapy? [If no, then no further questions.]	Yes	No
7	Does the patient have human epidermal growth factor receptor 2 (HER2)- negative disease? [If no, then no further questions.]	Yes	No

8	Does the patient have a BRCA (breast cancer susceptibility gene) 1/2-germline mutated disease? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of metastatic pancreatic adenocarcinoma? [If no, then skip to question 12.]	Yes	No
10	Has the disease progressed on at least 16 weeks of a first line platinum-based chemotherapy regimen? [If yes, then no further questions.]	Yes	No
11	Does the patient have a deleterious or suspected deleterious germline BRCA (breast cancer susceptibility gene) mutation? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of prostate cancer? [If no, then skip to question 16.]	Yes	No
13	Does the patient have BRCA (breast cancer susceptibility gene) mutated disease? [If no, then skip to question 15.]	Yes	No
14	Will the requested drug be used in combination with abiraterone and an oral corticosteroid? [If yes, then no further questions.]	Yes	No
15	Has the patient progressed on prior treatment with an androgen receptor-directed therapy? [No further questions.]	Yes	No
16	Does the patient have a diagnosis of uterine leiomyosarcoma? [If no, then no further questions.]	Yes	No
17	Has the patient had at least one prior therapy? [If no, then no further questions.]	Yes	No
18	Does the patient have BRCA (breast cancer susceptibility gene)-altered disease?	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:**_____