

Prescriber Criteria Form  
Piqray 2026 PA Fax 3090-A v1 010126.docx  
Piqray (alpelisib)  
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 Piqray (alpelisib).

Drug Name:  
Piqray (alpelisib)

<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>	

<b>Please circle the appropriate answer for each question.</b>			
1	Does the patient have a diagnosis of breast cancer? [If no, then no further questions.]	Yes	No
2	Is the disease recurrent, 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	Will the requested drug be used in combination with fulvestrant?	Yes	No

Comments:	
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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:** \_\_\_\_\_