Prescriber Criteria Form Truqap 2026 PA Fax 6266-A v1 010126.docx Truqap (capivasertib) 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 Truqap (capivasertib).

Drug Name: Truqap (capivasertib)

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 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's disease meet all of the following: A) hormone receptor (HR)-positive, B) human epidermal growth factor receptor 2 (HER2)-negative? [If no, then no further questions.]	Yes	No
4	Does the patient's disease possess one or more PIK3CA/AKT/PTEN-alteration? [If no, then no further questions.]	Yes	No
5	Does the patient meet one of the following: A) progression on at least one endocrine therapy based regimen, B) has the patient experienced recurrence on or within 12 months of completing adjuvant therapy? [If no, then no further questions.]	Yes	No
6	Will the requested drug be used in combination with 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:_____