Actimmune

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the diagnosis?

❒ Chronic granulomatous disease (CGD), *Continue to 2*

❒ Severe, malignant osteopetrosis (SMO), *Continue to 3*

❒ Mycosis fungoides (type of cutaneous T-cell lymphoma), *Continue to 4*

❒ Sezary syndrome (type of cutaneous T-cell lymphoma), *Continue to 4*

❒ Other, please specify. _____, *No further questions*

2. Is the requested drug prescribed by or in consultation with an immunologist or prescriber who specializes in the management of chronic granulomatous disease (CGD)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

3. Is the requested drug prescribed by or in consultation with an endocrinologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

4. Is the requested drug prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 6*
❒ No, *Continue to 7*

6. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. What is the diagnosis?

❒ Chronic granulomatous disease (CGD), *Continue to 8*

❒ Severe, malignant osteopetrosis (SMO), *Continue to 9*

❒ Mycosis fungoides (type of cutaneous T-cell lymphoma), *No further questions*

❒ Sezary syndrome (type of cutaneous T-cell lymphoma), *No further questions*

8. Will the requested drug be used to reduce the frequency and severity of infections associated with the patient's disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Will the requested drug be used to delay time to disease progression?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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