Adakveo

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.

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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*

What is the ICD-10 code? _____

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Adakveo 3412-A SGM SOC 5366-A – 08/2024.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital - *Continue to B*
- ❑ On-campus Outpatient Hospital - *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes - *skip to Clinical Criteria Questions*
- ❑ No - *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months). *If No, skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No - *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No - *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No - *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No - *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *continue to Clinical Criteria Questions*
- ❑ No, *continue to Clinical Criteria Questions*

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Clinical Criteria Questions:

1. What is the diagnosis?

❒ Sickle cell disease (If checked, go to 2)

❒ Other, please specify. (If checked, go to 2)

2. Is Adakveo being requested for use in reducing the frequency of vasoocclusive crises (VOCs)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is Adakveo being prescribed by or in consultation with a hematologist or specialist in sickle cell disease?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 5*
❒ No, *Continue to 6*

5. Has the patient experienced a reduction in the frequency of vasoocclusive crises, or has the patient maintained a reduction in the frequency of vasoocclusive crises, since initiating therapy with Adakveo?
❒ Yes, No Further Questions
❒ No, *No Further Questions*

6. Has the patient experienced a vasoocclusive crisis (VOC) in the past 12 months?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's sickle cell genotype?

❒ Homozygous hemoglobin S (HbSS) (If checked, go to 8)

❒ Sickle beta0-thalassemia (HbSbeta0) (If checked, go to 8)

❒ Sickle hemoglobin C (HbSC) (If checked, go to 11)

❒ Sickle beta+-thalassemia (HbSbeta+) (If checked, go to 11)

❒ Other/Unknown (If checked, *no further questions*)

8. Has the patient experienced, at any time in the past, an inadequate response or intolerance to a trial of hydroxyurea?

❒ Yes, inadequate response (If checked, go to 11)

❒ Yes, intolerance (If checked, go to 11)

❒ No (If checked, go to 9)

9. Does the patient have a contraindication to hydroxyurea?
❒ Yes, *Continue to 11*
❒ No, *Continue to 10*

10. Will the patient be using Adakveo with concurrent hydroxyurea therapy?
❒ Yes, Continue to 11
❒ No, Continue to 11

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11. What is the patient's age (in years)?

❒ In-Between Numbers: 15.9999 and 9999.0 (If checked, *no further questions*)

❒ Outside In-Between Numbers: 15.9999 and 9999.0 (If checked, *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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