



Alhemo

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

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

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

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Exception Criteria Questions:

A. Is the product being requested for any of the following:

- Hemophilia A prophylaxis, *Skip to Clinical Criteria Questions*
- Hemophilia B prophylaxis in the presence of Factor IX inhibitors, *Skip to Clinical Criteria Questions*
- No, *Continue to Question B*

B. Is the product being requested for Hemophilia B?

- Yes, *Continue to Question C*
- No, *Skip to Clinical Criteria Questions*

C. Did the patient have a documented inadequate response, contraindication, or intolerable adverse event to all preferred products (Alprolix, Benefix, and Idelvion)? **ACTION REQUIRED:** *If 'Yes', attach supporting chart note(s)*

- Yes, *Continue to Clinical Criteria Questions*
- No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. What is the diagnosis?

- Hemophilia A (congenital factor VIII deficiency), *Continue to 2*
- Hemophilia B (congenital factor IX deficiency), *Continue to 2*
- Other, please specify. _____, *Continue to 2*

2. Will the requested drug be prescribed by or in consultation with a hematologist?

- Yes, *Continue to 3*
- No, *Continue to 3*

3. Is the request for continuation of therapy?

- Yes, *Continue to 4*
- No, *Continue to 6*

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? **ACTION REQUIRED:** *If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds). ACTION REQUIRED: Submit supporting documentation*

- Yes, *Continue to 5*
- No, *Continue to 5*

5. Will the requested drug be used in combination with bypassing agents (e.g., FEIBA, NovoSeven), factor VIII products (e.g., Advate, Adynovate, Eloctate), or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use?

- Yes, *No Further Questions*
- No, *No Further Questions*

6. What is the patient's age?

- 12 years of age or older, *Continue to 7*
- Less than 12 years of age, *Continue to 7*

7. Is the patient's weight greater than 25 kg?

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- Yes, *Continue to 8*
- No, *Continue to 8*

8. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?

- Yes, *Continue to 9*
- No, *Continue to 9*

9. Does the patient have a history, current signs or symptoms, or is at high risk of thromboembolic events?

- Yes, *Continue to 10*
- No, *Continue to 10*

10. Is the patient currently undergoing or is planning to undergo immune tolerance treatment?

- Yes, *Continue to 11*
- No, *Continue to 11*

11. Does the patient have a platelet count of less than 100,000 cells/microL at baseline? **ACTION REQUIRED:** If No, please attach chart notes, lab tests documenting baseline platelet count. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 12*
- No, *Continue to 12*

12. Does the patient have an alanine transaminase (ALT) and/or aspartate aminotransferase (AST) greater than 3 times the upper limit of normal (ULN) at baseline? **ACTION REQUIRED:** If No, please attach chart notes, lab tests documenting baseline liver function tests. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 13*
- No, *Continue to 13*

13. Does the patient have a total bilirubin level greater than 1.5 times ULN (unless there is a diagnosis of Gilbert's Syndrome and the patient is otherwise stable) at baseline? **ACTION REQUIRED:** If No, please attach chart notes, lab tests documenting baseline total bilirubin level. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 14*
- No, *Continue to 14*

14. Does the patient have a fibrinogen level below the laboratory lower limit of normal at baseline? **ACTION REQUIRED:** If No, please attach chart notes, lab tests documenting baseline fibrinogen level. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 15*
- No, *Continue to 15*

15. Does the patient have an estimated glomerular filtration rate (eGFR) less than or equal to 30 mL/min/1.73 m²? **ACTION REQUIRED:** If No, please attach chart notes, lab tests documenting baseline eGFR rate. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 16*
- No, *Continue to 16*

16. Will the requested drug be used in combination with Hemlibra, Hympavzi, or Qfitlia ?

- Yes, *Continue to 17*
- No, *Continue to 17*

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17. Has the patient previously received treatment with a gene therapy product (e.g., Beqvez, Hemgenix, Roctavian) for the treatment of hemophilia A or B?

Yes, *Continue to 18*

No, *Continue to 18*

18. Will prophylactic use of bypassing agents (e.g., FEIBA, NovoSeven), factor VIII products (e.g., Advate, Adynovate, Eloctate), and factor IX products (e.g., Alprolix, Ixinity, Rebinyn) be discontinued prior to starting therapy with the requested drug?

Yes, *Continue to 19*

No, *Continue to 19*

19. Does the provider attest that concizumab-mtci plasma concentrations will be monitored per the protocol outlined in the prescribing information?

Yes, *No Further Questions*

No, *No Further Questions*

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Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug FDA-approved for the medical condition being treated? <i>If No, No Further Questions</i>	Yes	No
4. Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days? <i>If No, Skip to 6</i>	Yes	No
5. Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition? <i>If Yes or No, No Further Questions</i>	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? <i>If Yes, No Further Questions</i>	Yes	No
7. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen? <i>If Yes, No Further Questions</i>	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? <i>If Yes, No Further Questions</i>	Yes	No
9. Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? <i>No Further Questions</i>	Yes	No

Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug contraindicated? <i>If Yes, No Further Questions</i>	Yes	No
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? <i>If Yes, No Further Questions</i>	Yes	No
5. Has the patient tried the alternate drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? NOTE: Pharmaceutical drug samples are not considered trial and failure of a preferred drug. <i>If Yes, No Further Questions</i>	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? <i>No Further Questions</i>	Yes	No

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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