Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Aveed

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

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Criteria Questions:

1. What is the diagnosis?
❒ Primary hypogonadism, *Continue to 2*
❒ Hypogonadotropic hypogonadism, *Continue to 2*
❒ Age-related hypogonadism, *No further questions*
❒ Late-onset hypogonadism, *No further questions*
❒ Gender dysphoria (including transgender and gender diverse [TGD] persons), *Continue to 9*
❒ Other, please specify. _____, *No further questions*

2. What is the patient's gender?
❒ Biological male or a person that self identifies as male, *Continue to 3*
❒ Female, *Continue to 3*

3. Is the patient 18 years of age or older?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the request for continuation of therapy?
❒ Yes, *Continue to 5*
❒ No, *Continue to 7*

5. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 7*
❒ No, *Continue to 6*
❒ Unknown, *Continue to 7*

6. Before the start of therapy, did the patient have at least two serum total testosterone concentrations that were confirmed to be low based on the reference laboratory range or current practice guidelines, each taken in the morning on separate days?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Prior to initiating therapy with the requested drug, did the patient have at least two pretreatment serum total testosterone concentrations that were confirmed to be low based on the reference laboratory range or current practice guidelines, each taken in the morning on separate days? ***ACTION REQUIRED***: If Yes, attach copy of laboratory report with pretreatment morning serum total testosterone concentrations.
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*
❒ Unknown, *Continue to 8*

8. Is the copy of the laboratory report with pretreatment morning serum total testosterone concentrations attached to this request?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Will the requested drug be used for gender-affirming care?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the patient less than 18 years of age?

❒ Yes, *Continue to 11*
❒ No, *Continue to 12*

11. Is the requested drug prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient able to make an informed decision to engage in hormone therapy?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Is the request for continuation of therapy?
❒ Yes, *Continue to 19*
❒ No, *Continue to 16*

16. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the requested drug prescribed for gender dysphoria in an adolescent patient?
❒ Yes, *Continue to 18*
❒ No, *No Further Questions*

18. What Tanner stage of puberty has the patient reached?
❒ Tanner stage 1, *No further questions*
❒ Tanner stage 2, *No further questions*
❒ Tanner stage 3, *No further questions*
❒ Tanner stage 4, *No further questions*
❒ Tanner stage 5, *No further questions*
❒ Unknown, *No further questions*

19. Is the requested drug prescribed for gender dysphoria in an adolescent patient?
❒ Yes, *Continue to 20*
❒ No, *Continue to 21*

20. Which Tanner stage of puberty has the patient reached previously?
❒ Tanner stage 1, *Continue to 21*
❒ Tanner stage 2, *Continue to 21*
❒ Tanner stage 3, *Continue to 21*
❒ Tanner stage 4, *Continue to 21*

❒ Tanner stage 5, *Continue to 21*
❒ Unknown, *Continue to 21*

21. Has the patient been informed of fertility preservation options before the start of therapy?
❒ 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)**

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