Cablivi

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

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Acquired thrombotic thrombocytopenic purpura (aTTP), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced more than 2 recurrences of acquired thrombotic thrombocytopenic purpura (aTTP) while on the requested medication? Note: A recurrence is when the patient needs to reinitiate plasma exchange. A 28-day extension of therapy does not count as a recurrence.

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

❒ Unknown, *Continue to 3*

3. Please indicate the clinical setting for which the requested medication will be used. Note: Initial course of the requested medication is treatment with the requested medication during and 30 days after plasma exchange. A recurrence is when the patient needs to reinitiate plasma exchange. A 28-day extension of therapy does not count as a recurrence.

❒ Directly following an initial 30-day course of the requested medication, as an extension of therapy for persistent underlying aTTP., *Continue to 7*

❒ Directly following the completion of plasma exchange in the hospital., *Continue to 4*

4. Did the patient receive the requested medication with plasma exchange?

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Will the requested medication be given in combination with immunosuppressive therapy?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Will the patient receive the requested medication beyond 30 days from the cessation of plasma exchange (excluding when the patient has documented persistent aTTP)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. Does the patient have signs of persistent underlying aTTP?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. What is the patient's ADAMTS13 activity level? ***ACTION REQUIRED***: Attach supporting chart note(s).

❒ Less than 10% ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*

❒ 10% or greater ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ Unknown, *Continue to 9*

9. Does the patient have all of the following: a) Microangiopathic hemolytic anemia (MAHA) documented by the presence of schistocytes on peripheral smear, b) Thrombocytopenia (platelet count below normal per laboratory reference range), and c) Elevated lactate dehydrogenase (LDH) level (LDH level above normal per laboratory reference range)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s).

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Will the requested medication be given in combination with immunosuppressive therapy?

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

11. For this course of treatment, has the patient received a prior 28-day extension of therapy after the initial course 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

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