Crysvita

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*

What is the ICD-10 code? _____

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

 Crysvita 2562-A SGM SOC 5377-A – 02/2025.

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)., *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 or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration? ***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 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 G*

G. 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*

Criteria Questions:

1. What is the diagnosis?

❒ X-linked hypophosphatemia (XLH), *Continue to 2*
❒ Fibroblast growth factor 23 (FGF23)-related hypophosphatemia in tumor-induced osteomalacia (TIO), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 5*
❒ No, *Continue to 4*
❒ Unknown, *Continue to 5*

4. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease improvement or disease stability (e.g., increase or normalization in serum phosphate, improvement in bone and joint pain, reduction in fractures, improvement in skeletal deformities)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation showing beneficial response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the diagnosis?

❒ X-linked hypophosphatemia (XLH), *Continue to 6*
❒ Fibroblast growth factor 23 (FGF23)-related hypophosphatemia in tumor-induced osteomalacia (TIO), *Continue to 10*

6. Does the patient have a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing? ***ACTION REQUIRED***: If Yes, please attach genetic testing results confirming the PHEX mutation.
❒ Yes, *Continue to 9*
❒ No, *Continue to 7*

7. Does the patient have a directly related family member with appropriate X-linked inheritance with a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing? ***ACTION REQUIRED***: If Yes, please attach genetic testing results confirming PHEX mutation in a directly related family member with appropriate X-linked inheritance.
❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Is the patient's serum fibroblast growth factor 23 (FGF23) level above the upper limit of normal or abnormal for the assay? ***ACTION REQUIRED***: If Yes, please attach lab test results showing the patient's serum FGF23 level is above the upper limit of normal or abnormal for the assay.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ No, *Continue to 9*

❒ Unknown, *Continue to 9*

9. Does the patient have radiographic evidence of rickets or other bone disease attributed to X-linked hypophosphatemia (XLH)? ***ACTION REQUIRED***: If Yes, please attach radiographic evidence of rickets or other bone disease attributed to XLH.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Is the patient's disease associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient's serum fibroblast growth factor 23 (FGF23) level above the upper limit of normal or abnormal for the assay? ***ACTION REQUIRED***: If Yes, please attach lab test results confirming the patient's FGF23 level is above the upper limit of normal or abnormal for the assay.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 12*

12. What is the patient's fasting serum phosphorus level? ***ACTION REQUIRED***: Please attach patient's fasting serum phosphorus level.

❒ Greater than or equal to 2.5 mg/dL, *Continue to 13*

❒ Less than 2.5 mg/dL ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ Unknown, *Continue to 13*

13. What is the patient's ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR)? ***ACTION REQUIRED***: Please attach patient's ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR).

❒ Greater than or equal to 2.5 mg/dL, *No further questions*

❒ Less than 2.5 mg/dL ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *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)**