Encelto

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

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. CareFirst Encelto SGM 7026-A – 04/2026.

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

Criteria Questions:

1. What is the diagnosis?
❒ Idiopathic Macular Telangiectasia Type 2 (MacTel), *Continue to 2*
❒ Other, please specify_____, *Continue to 2*

2. Is there evidence of intraretinal neovascularization or subretinal neovascularization (SRNV) (e.g., neovascular MacTel), as evidenced by hemorrhage, hard exudate, subretinal fluid or intraretinal fluid in either eye?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Has the patient received intravitreal steroid therapy for non-neovasular MacTel within the past 3 months?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Has the patient previously received intravitreal anti-vascular endothelial growth factor (VEGF) therapy in the affected eye(s) or has received intravitreal anti-VEGF in the non-affected eye within the past 3 months?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is there evidence of central serous chorio-retinopathy in either eye?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is there evidence of pathologic myopia in either eye?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have significant corneal or media opacities in either eye?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient had a vitrectomy, penetrating keratoplasty, trabeculectomy, or trabeculoplasty?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have any of the following lens opacities: a) Cortical opacity greater than standard 3, b) Posterior subcapsular opacity greater than standard 2, or c) A nuclear opacity greater than standard 3 as measured on the Age-Related Eye Disease Study (AREDS) clinical lens grading system?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient undergone lens removal in the previous 3 months or YAG laser within 4 weeks?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have evidence of intraretinal hyperreflectivity by optical coherence tomography (OCT)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

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12. Is the patient on chemotherapy?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have a history of ocular herpes virus in either eye?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Does the patient have an ocular or periocular infection?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have a known hypersensitivity to Endothelial Serum Free Media (Endo-SFM)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have any of the following comorbidities: a) Glaucoma, b) Severe nonproliferative or proliferative diabetic retinopathy, or c) Uveitis?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient able to temporarily discontinue antithrombotic therapy (e.g., oral anticoagulants, aspirin, nonsteroidal anti-inflammatory drugs) prior to insertion surgery to reduce the risk of implantation related vitreous hemorrhage?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient received a previous treatment course with the requested drug in the affected eye(s)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the requested drug being prescribed by or in consultation with an ophthalmologist?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Does the patient have at least one eye positive for the diagnosis of idiopathic macular telangiectasia type 2 (MacTel) as evidenced by fluorescein leakage with at least one of the following features: a) Hyperpigmentation that is outside of a 500 micron radius from the center of the fovea, b) Retinal opacification, c) Crystalline deposits, d) Right-angle vessels, or e) Inner/outer lamellar cavities? ***ACTION REQUIRED***: If Yes, please attach medical records, chart notes or laboratory reports confirming the diagnosis. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Does the patient have a photoreceptor inner segment/outer segment (IS/OS PR) break (loss) in ellipsoid zone (EZ) (area of IS/OS loss) between 0.16 mm2 and 2.00 mm2 measured by spectral domain-optical coherence tomography (SD-OCT)? ***ACTION REQUIRED***: If Yes, please attach medical records or chart notes documenting the spectral domain-optical coherence tomography (SD-OCT) results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

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22. Does the patient have a best corrected visual acuity (BCVA) of a 54-letter score or better (20/80 or better) as measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart at screening? ***ACTION REQUIRED***: If Yes, please attach medical records or chart notes documenting the best corrected visual acuity (BCVA) results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Does the patient have steady fixation and sufficiently clear ocular media for good quality photographs?
❒ 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)**

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