Exdensur

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

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

Exception Criteria Questions:

1. Is the product being requested for a patient with asthma?
❒ Yes, *Continue to Question 2*
❒ No, *Skip to Clinical Criteria Questions*

2. The preferred products for your patient's health plan are Fasenra, Nucala, Xolair, and Tezspire
Can the patient's treatment be switched to one of the preferred products?
❒ Yes, Fasenra, *Please obtain Form for preferred product and submit for corresponding PA*
❒ Yes, Nucala, *Please obtain Form for preferred product and submit for corresponding PA*
❒ Yes, Xolair, *Please obtain Form for preferred product and submit for corresponding PA*
❒ Yes, Tezspire, *Please obtain Form for preferred product and submit for corresponding PA*
❒ No, *Continue to Question 3*

3. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all preferred products (Fasenra, Nucala, Xolair, and Tezspire)? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. Will the requested drug be used concomitantly with any other biologic or targeted synthetic drug for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Severe asthma, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

3. Is the requested drug being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient 12 years of age or older?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 6*
❒ No, *Continue to 10*

6. Is the patient currently receiving Exdensur through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 10*
❒ No, *Continue to 7*
❒ Unknown, *Continue to 10*

7. Has asthma control improved on Exdensur treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Has asthma control improved on Exdensur treatment as demonstrated by a reduction or discontinuation in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid and additional controller) in combination with Exdensur?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Has the patient received in the past 12 months or is currently receiving a biologic drug (e.g., Dupixent, Nucala) indicated for treatment of asthma (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Prior to requesting Exdensur, what is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count? Indicate baseline blood eosinophil count in cells per microliter. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation with the patient's baseline blood eosinophil count.
❒ Greater than or equal to 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Less than 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

12. Is the patient dependent on oral systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation showing the patient's dependance on systemic corticosteroids. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 16*
❒ No, *Continue to 14*

14. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of previous asthma exacerbation(s) requiring hospitalization or emergency medical visit(s). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 16*
❒ No, *Continue to 15*

15. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of poor symptom control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Prior to requesting Exdensur, did the patient have inadequate asthma control despite adherence to current treatment with both of the following medications at maximal optimized doses: A) High-dose inhaled corticosteroid, AND B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline). ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid and additional controller) in combination with Exdensur?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.	Please Circle	
1. Is the requested drug being prescribed 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? *If No, No Further Questions*	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? *If No, Skip to 6*	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? *If Yes*, *No Further Questions*	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? *If Yes, No Further Questions*	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? *If Yes, No Further Questions*	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? *If Yes, No Further Questions*	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? *No Further Questions*	Yes	No

Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.	Please Circle	
1. Is the requested drug being prescribed 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? *If Yes, No Further Questions*	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? *If Yes, No Further Questions*	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. *If Yes, No Further Questions*	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? *No Further Questions*	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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