GamaSTAN

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

 GamaSTAN SGM 2067-A – 01/2025.

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

Criteria Questions:

1. What is the intended use for GamaSTAN?

❒ Prophylaxis of hepatitis A, *Continue to 2*

❒ Prophylaxis of measles (rubeola), *Continue to 5*

❒ Prophylaxis of varicella (chickenpox), *Continue to 8*

❒ Prophylaxis of rubella, *Continue to 11*

❒ Other, please specify. _____, *No further questions*

2. Was the patient exposed to hepatitis A virus within the past 2 weeks (e.g., household contact, sexual contact, childcare center or classroom contact with an infected person)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Is the patient exhibiting clinical manifestation of disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Is the patient at high risk for exposure to hepatitis A virus (examples of populations at high risk for hepatitis A are travelers to and workers in countries of high endemicity of infection and illicit drug users)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Was the patient exposed to measles within the past 6 days?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Has the patient ever received the measles vaccine (e.g., MMR)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient ever had the measles?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Was the patient exposed to varicella within the past 10 days?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the patient at high risk for severe varicella (e.g., immunocompromised, newborn/infant, pregnant woman)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is varicella zoster immune globulin (e.g., Varizig) not currently available?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Was the patient recently exposed to rubella?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the patient currently pregnant?
❒ 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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