



Givlaari

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.

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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

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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 an 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*

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Criteria Questions:

1. What is the diagnosis?

☐ Acute hepatic porphyria, *Continue to 2*

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

2. Is the patient currently receiving treatment with the requested medication?

☐ Yes, *Continue to 8*

☐ No, *Continue to 3*

3. Is the patient actively symptomatic (e.g., porphyria attacks requiring hospitalization, urgent healthcare visits, or intravenous hemin administration), or the patient has experienced 4 or more porphyria attacks per year?

☐ Yes, *Continue to 4*

☐ No, *Continue to 4*

☐ Unknown, *Continue to 4*

4. Has the patient been tested for porphobilinogen (PBG) in the urine confirmed by a PBG quantitative, random urine test? **ACTION REQUIRED:** If Yes, attach supporting chart note(s).

☐ Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 5*

☐ No, *Continue to 6*

☐ Unknown, *Continue to 6*

5. Is the porphobilinogen level above lab reference range? **ACTION REQUIRED:** If Yes, attach supporting chart note(s). **ACTION REQUIRED:** *Submit supporting documentation*

☐ Yes, *No Further Questions*

☐ No, *Continue to 6*

6. Has the patient been tested for a plasma or fecal porphyrin level? **ACTION REQUIRED:** If Yes, attach supporting chart note(s).

☐ Yes **ACTION REQUIRED:** *Submit supporting documentation, Continue to 7*

☐ No, *Continue to 7*

☐ Unknown, *Continue to 7*

7. Is the plasma or fecal porphyrin level above lab reference range? **ACTION REQUIRED:** If Yes, attach supporting chart note(s). **ACTION REQUIRED:** *Submit supporting documentation*

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

8. Is the patient receiving benefit from therapy (e.g., reduction in porphyria attacks that required hospitalizations, urgent healthcare visit, or intravenous hemin administration)?

☐ 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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