



Alphanate, Humate-P 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

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? _____

Criteria Questions:

What drug is being prescribed? ☐ Alphanate ☐ Humate-P ☐ Other _____

1. What is the diagnosis?

- ☐ Hemophilia A, *Continue to 2*
☐ von Willebrand disease, *Continue to 2*
☐ Acquired von Willebrand syndrome (AVWS), *Continue to 2*
☐ Acquired hemophilia A, *Continue to 2*
☐ Other, please specify. _____, *No further questions*

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. Hemo - Alphanate, Humate-P SGM 1939-A - 04/2024.

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2. Will the requested medication be prescribed by or in consultation with a hematologist?

☐ Yes, *Continue to 3*

☐ No, *Continue to 3*

3. Is the request for continuation of therapy?

☐ Yes, *Continue to 13*

☐ No, *Continue to 4*

4. What is the diagnosis?

☐ Hemophilia A, *Continue to 5*

☐ von Willebrand disease, *Continue to 9*

☐ Acquired von Willebrand syndrome (AVWS), *No further questions*

☐ Acquired hemophilia A, *No further questions*

5. What is the patient's baseline factor VIII assay level (% activity)?

☐ Less than 1% to 5% (moderate or severe disease), *No further questions*

☐ Greater than 5% (mild disease), *Continue to 6*

6. Has the patient had an insufficient response to desmopressin?

☐ Yes, *No Further Questions*

☐ No, *Continue to 7*

7. Is there a clinical reason for not trying desmopressin first?

☐ Yes, *Continue to 8*

☐ No, *Continue to 8*

8. What is the reason? Please indicate the clinical reason for not trying desmopressin first.

☐ Age less than 2 years, *No further questions*

☐ Pregnancy, *No further questions*

☐ Fluid/electrolyte imbalance, *No further questions*

☐ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No further questions*

☐ Predisposition to thrombus formation, *No further questions*

☐ Trauma requiring surgery, *No further questions*

☐ Life-threatening bleed, *No further questions*

☐ Contraindication or intolerance to desmopressin, *No further questions*

☐ Severe type 1 von Willebrand disease, *No further questions*

☐ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No further questions*

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

9. What type of von Willebrand disease does the patient have?

☐ Type 1, *Continue to 10*

☐ Type 2A, *Continue to 10*

☐ Type 2B, *No further questions*

☐ Type 2M, *Continue to 10*

☐ Type 2N, *Continue to 10*

☐ Type 3, *No further questions*

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

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10. Has the patient had an insufficient response to desmopressin?

☐ Yes, *No Further Questions*

☐ No, *Continue to 11*

11. Is there a clinical reason for not trying desmopressin first?

☐ Yes, *Continue to 12*

☐ No, *Continue to 12*

12. What is the reason? Please indicate the clinical reason for not trying desmopressin first.

☐ Age less than 2 years, *No further questions*

☐ Pregnancy, *No further questions*

☐ Fluid/electrolyte imbalance, *No further questions*

☐ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No further questions*

☐ Predisposition to thrombus formation, *No further questions*

☐ Trauma requiring surgery, *No further questions*

☐ Life-threatening bleed, *No further questions*

☐ Contraindication or intolerance to desmopressin, *No further questions*

☐ Severe type 1 von Willebrand disease, *No further questions*

☐ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No further questions*

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

13. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?

☐ 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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