Hympavzi

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

 CareFirst Hympavzi SGM 6702-A – 07/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Hemophilia A (congenital factor VIII deficiency), *Continue to 2*

❒ Hemophilia B (congenital factor IX deficiency), *Continue to 20*

❒ Other, please specify. _____, *No Further Questions*

2. Will the requested drug 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 4*

❒ No, *Continue to 7*

4. Does the patient have any detectable or documented history of factor VIII inhibitors?

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ***ACTION REQUIRED***: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds).

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Will the requested drug be used in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate) for prophylactic use?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

7. What is the patient's age?

❒ 12 years of age or older, *Continue to 8*

❒ Less than 12 years of age, *Continue to 8*

8. Is the patient's weight greater than or equal to 35 kg?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Does the patient have any detectable or documented history of factor VIII inhibitors? ***ACTION REQUIRED***: If No, please attach chart notes, lab tests documenting the absence of factor VIII inhibitors (lab test results required).

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Does the patient have severe factor VIII deficiency (defined as factor VIII level of less than 1%)? ***ACTION REQUIRED***: If Yes, please attach chart notes, lab tests documenting severe factor VIII deficiency (factor VIII level of less than 1%).

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Will the patient be using the requested drug to treat breakthrough bleeding?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient had an inadequate response, intolerance, or contraindication to compliant use of a factor VIII product (e.g., Advate, Adynovate, Eloctate)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 14*

14. Has the patient had at least 6 acute bleeding episodes in the previous 6 months?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have unstable or abnormal hepatic, biliary, or renal function/disease?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the requested drug be used in combination with Hemlibra?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient previously received treatment with a gene therapy product (e.g., Roctavian) for the treatment of hemophilia A?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will prophylactic use of factor VIII products be discontinued prior to starting therapy with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Will the requested drug be prescribed by or in consultation with a hematologist?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Is the request for continuation of therapy?
❒ Yes, *Continue to 22*
❒ No, *Continue to 25*

22. Does the patient have any detectable or documented history of factor IX inhibitors?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ***ACTION REQUIRED***: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds).
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Will the requested drug be used in combination with factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. What is the patient's age?
❒ 12 years of age or older, *Continue to 26*
❒ Less than 12 years of age, *Continue to 26*

26. Is the patient's weight greater than or equal to 35 kg?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Does the patient have moderately severe to severe factor IX deficiency (defined as factor IX level of less than or equal to 2%)? ***ACTION REQUIRED***: If Yes, please attach chart notes, lab tests documenting moderately severe to severe factor IX deficiency (factor IX level of less than or equal to 2%).
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Does the patient have any detectable or documented history of factor IX inhibitors? ***ACTION REQUIRED***: If No, please attach chart notes, lab tests documenting the absence of factor IX inhibitors (lab test results required).
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Will the patient be using the requested drug to treat breakthrough bleeding?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Has the patient had an inadequate response, intolerance, or contraindication to compliant use of a factor IX product (e.g., Alprolix, Ixinity, Rebinyn)?
❒ Yes, *Continue to 33*
❒ No, *Continue to 32*

32. Has the patient had at least 6 acute bleeding episodes in the previous 6 months?

❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Does the patient have a history of coronary artery disease, venous or arterial thrombosis or ischemic disease?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Does the patient have unstable or abnormal hepatic, biliary, or renal function/disease?
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Has the patient previously received treatment with a gene therapy product (e.g., Hemgenix) for the treatment of hemophilia B?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Will prophylactic use of factor IX products be discontinued prior to starting therapy with the requested drug?
❒ 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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720