Imaavy

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 SOC 6690-A Imaavy SGM 6994-A – 10.2025.

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

Site of Service Questions (SOS):

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 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 severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. 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 H*

H. 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*

Criteria Questions:

1. What is the diagnosis?

❒ Generalized myasthenia gravis (gMG), *Continue to 2*

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

2. Will the requested medication be used in combination with another neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart, Vyvgart Hytrulo) or complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to 4*

❒ No, *Continue to 6*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Has the patient demonstrated a positive response to therapy (e.g., improvement in MG-ADL score, MG Manual Muscle Test (MMT), MG Composite)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. Is the requested medication being used to treat a patient who is anti-acetylcholine receptor (AchR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive? ***ACTION REQUIRED***: If Yes, please attach documentation of positive anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody test.

❒ Yes, *Continue to 7*

❒ No, *Continue to 7*

7. What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification? ***ACTION REQUIRED***: Please attach documentation of MGFA clinical classification.

❒ Class I ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 8*

❒ Class II ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 8*

❒ Class III ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 8*

❒ Class IV ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 8*

❒ Class V ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 8*

❒ Unknown, *Continue to 8*

8. What is the patient's score on the MG activities of daily living (MG-ADL)? ***ACTION REQUIRED***: Please attach documentation of MG-ADL score.

_____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 9*

9. Has the patient had an inadequate response or intolerable adverse event to at least two immunosuppressive therapies over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, tacrolimus)? ***ACTION REQUIRED***: If Yes, please attach documentation of previous medications tried, including response to therapy.

❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient had an inadequate response or intolerable adverse event to at least one immunosuppressive therapy and intravenous immunoglobulin (IVIG) over the course of at least 12 months? ***ACTION REQUIRED***: If Yes, please attach documentation of previous medications tried, including response to therapy.

❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have a documented clinical reason to avoid therapy with immunosuppressive agents and IVIG? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of clinical reasons to avoid therapy. Note: Submit supporting documentation

❒ 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