Kebilidi

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 Kebilidi SGM 6952-A – 07/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Aromatic L-amino acid decarboxylase (AADC) deficiency, *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Are the patient's anti-adeno-associated virus, serotype 2 (anti-AAV2) antibody titers greater than 1:1200?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Does the patient have a pyridoxine 5'-phosphate oxidase or tetrahydrobiopterin (BH4) deficiency?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Does the patient have evidence of a clinically active infection?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be prescribed by or in consultation with a neurologist, geneticist, or physician specializing in the treatment of inherited metabolic diseases?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the patient's age?
_____ years of age, *Continue to 7*

7. Does the patient's cerebrospinal fluid (CSF) have abnormal levels of neurotransmitter metabolites associated with AADC deficiency (i.e., reduced levels of 5-hydroxyindoleacetic acid [5-HIAA], homovanillic acid [HVA] and 3-methoxy-4-hydroxyphenylglycol [MHPG]; with normal CSF pterins including neopterin and biopterin; and increased CSF levels of L-Dopa, 3-O-methyldopa [3-OMD] and 5-OH tryptophan [5-HTP])? ***ACTION REQUIRED***: If Yes, please attach medical record documentation or chart notes of cerebrospinal fluid (CSF) test results.
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have decreased AADC activity in the plasma?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have a documented AADC deficiency due to biallelic variants in the DDC gene? ***ACTION REQUIRED***: If Yes, please attach genetic test results identifying pathogenic variants in the DDC gene confirming the diagnosis of AADC deficiency.
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Does the patient have persistent neurological defects (e.g., developmental delays, movement disorders [dystonia, hypokinesia, hypotonia, oculogyric crises], autonomic dysfunction [hyperhidrosis, hypersalivation, hypotension, hypoglycemia, ptosis], intellectual disability) despite standard medical therapy (i.e., dopamine agonists, monoamine oxidase inhibitor, pyridoxine or other forms of vitamin B6)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient able to ambulate independently with or without an assistive device?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is there documentation on a formal radiology report that the patient's skull maturity is sufficient for stereotaxis, namely development of three distinct skull layers (inner and outer cortical and middle cancellous)?
ACTION REQUIRED: If Yes, please attach radiology report documenting the patient's skull maturity.
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Will a brain MRI be used for stereotactic planning and intraoperative navigation?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Will the requested drug be administered in a medical center which specializes in stereotactic neurosurgery?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the dose exceed 1.8 x 10(11) vector genomes (vg)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Please indicate the anticipated date of administration for the requested drug.
❒ Please indicate date of administration: _____ MM/DD/YYYY, *No Further Questions*
❒ Date unknown, *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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