



Kresladi

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*

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

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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

Criteria Questions:

1. What is the diagnosis?

☐ Severe Leukocyte Adhesion Deficiency-I (LAD-I), *Continue to 2*

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

2. What is the patient's age?

_____ years of age, *Continue to 3*

3. Will the requested drug be prescribed by or in consultation with an immunologist, hematologist, or a physician who specializes in the treatment of leukocyte adhesion deficiency-I (LAD-I)?

☐ Yes, *Continue to 4*

☐ No, *Continue to 4*

4. Has the diagnosis been confirmed by the presence of biallelic pathogenic variants in the ITGB2 gene? **ACTION**

REQUIRED: If Yes, attach genetic testing results demonstrating a pathogenic variant in the ITGB2 gene.

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. Does the patient have flow cytometry results indicating CD18 expression on less than 2% of neutrophils

[polymorphonuclear neutrophils (PMNs)]? **ACTION REQUIRED:** If Yes, attach chart notes, medical records, or lab results of flow cytometry showing neutrophil CD18 expression.

☐ Yes, *Continue to 9*

☐ No, *Continue to 6*

6. Does the patient have flow cytometry results indicating CD18 expression on 2% or greater of neutrophils

[polymorphonuclear neutrophils (PMNs)]? **ACTION REQUIRED:** If Yes, attach chart notes, medical records, or lab results of flow cytometry showing neutrophil CD18 expression.

☐ Yes, *Continue to 7*

☐ No, *Continue to 7*

7. Does the patient have flow cytometry results indicating CD11a or CD11b expression on less than 2% of neutrophils

[polymorphonuclear neutrophils (PMNs)]? **ACTION REQUIRED:** If Yes, attach chart notes, medical records, or lab results documenting flow cytometry showing neutrophil CD11a or CD11b expression.

☐ Yes, *Continue to 8*

☐ No, *Continue to 8*

8. Does the patient have clinical history or known family history consistent with leukocyte adhesion deficiency-I (LAD-I)? **ACTION REQUIRED:** If Yes, attach chart notes, medical records, or test results documenting clinical history or

known family history consistent with leukocyte adhesion deficiency-I (LAD-I).

☐ Yes, *Continue to 9*

☐ No, *Continue to 9*

9. Has the patient had at least one prior significant bacterial or fungal infection or a documented family history of

leukocyte adhesion deficiency-I (LAD-I)? **ACTION REQUIRED:** If Yes, attach chart notes, medical records, or test results documenting prior significant bacterial/fungal infection or family history of leukocyte adhesion deficiency-I (LAD-I).

☐ Yes, at least one prior significant bacterial or fungal infection, *Continue to 10*

☐ Yes, documented family history of LAD-I, *Continue to 10*

☐ No, *Continue to 10*

10. Is the patient an appropriate candidate for hematopoietic stem cell transplant (HSCT) and has no medically-eligible human leukocyte antigen (HLA)-matched sibling donor?

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- ☐ Yes, *Continue to 11*
☐ No, *Continue to 11*

11. Does the patient have a negative serology test for human immunodeficiency virus 1 and 2 (HIV-1/HIV-2) and human T-lymphocytic virus 1 and 2 (HTLV-1/HTLV-2)?

- ☐ Yes, *Continue to 12*
☐ No, *Continue to 12*

12. Will the patient be assessed and monitored as directed in the manufacturer's prescribing information for the following: a) signs and symptoms of infection, b) signs and symptoms of veno-occlusive disease, c) neutrophil counts, d) platelet counts and bleeding, e) hematologic malignancies, and f) hypersensitivity reactions?

- ☐ Yes, *Continue to 13*
☐ No, *Continue to 13*

13. Does the patient have an alanine aminotransaminase (ALT) or aspartate aminotransferase (AST) value greater than 2.5 times the upper limit of normal as evidence of hepatic dysfunction? **ACTION REQUIRED:** Please attach chart notes, lab tests documenting alanine aminotransaminase (ALT) and aspartate aminotransferase (AST) levels.

- ☐ Yes, *Continue to 14*
☐ No, *Continue to 14*

14. Does the patient have a total bilirubin level greater than 1.5 times the upper limit of normal as evidence of hepatic dysfunction? **ACTION REQUIRED:** Please attach chart notes, lab tests documenting baseline total bilirubin level.

- ☐ Yes, *Continue to 15*
☐ No, *Continue to 15*

15. Does the patient have evidence of renal dysfunction (e.g., eGFR less than 60 ml/min/1.73 m²) or require dialysis or hemodialysis? **ACTION REQUIRED:** Please attach chart notes, lab tests documenting baseline renal function.

- ☐ Yes, *Continue to 16*
☐ No, *Continue to 16*

16. Has the patient required supplemental oxygen within two weeks of initiating therapy with the requested medication as evidence of pulmonary dysfunction?

- ☐ Yes, *Continue to 17*
☐ No, *Continue to 17*

17. Does the patient have oxygen saturation less than 90% (by pulse oximetry) as evidence of pulmonary dysfunction? **ACTION REQUIRED:** Please attach chart notes, lab tests documenting baseline pulmonary function.

- ☐ Yes, *Continue to 18*
☐ No, *Continue to 18*

18. Does the patient have evidence of active metastatic or locoregionally advanced malignancy (including hematologic malignancy)?

- ☐ Yes, *Continue to 19*
☐ No, *Continue to 19*

19. Is the patient infected with persistent bloodstream pathogens or other serious, untreated infections?

- ☐ Yes, *Continue to 20*
☐ No, *Continue to 20*

20. Does the patient have any medical or other contraindication for leukapheresis, bone marrow harvest, or conditioning procedures, in the opinion of the provider?

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- ☐ Yes, *Continue to 21*
☐ No, *Continue to 21*

21. Does the patient have evidence of significant medical conditions [e.g., poorly controlled diabetes, poorly controlled hypertension, poorly controlled cardiac arrhythmia, congestive heart failure; or arterial thromboembolic events (including stroke or myocardial infarction)] within 6 months of initiating treatment with the requested medication?

- ☐ Yes, *Continue to 22*
☐ No, *Continue to 22*

22. Has the patient previously received the requested drug or any other gene therapy?

- ☐ 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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