Lenmeldy

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

 Lenmeldy SGM 6640-A – 08/2024.

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?

❒ Metachromatic Leukodystrophy (MLD), *Continue to 2*

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

2. Does the patient have one of the following classifications of metachromatic leukodystrophy (MLD)? ***ACTION REQUIRED***: *If Yes, please attach chart notes or medical records documenting PSLI, PSEJ, or ESEJ classification of MLD*.

❒ Yes, Pre-symptomatic late infantile (PSLI) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 3*

❒ Yes, Pre-symptomatic early juvenile (PSEJ) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 3*

❒ Yes, Early symptomatic early juvenile (ESEJ) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 3*

❒ No, Other, please specify. _____, *Continue to 3*

3. Will the requested drug be prescribed by or in consultation with a physician who specializes in the treatment of metachromatic leukodystrophy (MLD)?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. Was the diagnosis confirmed by biochemical testing documenting ARSA activity that is below the normal range for the laboratory performing the test? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or lab results documenting deficiency of arylsulfatase A (ARSA) on biochemical testing.

❒ Yes, *Continue to 5*

❒ No, *Continue to 5*

5. Does the patient have the presence of two disease-causing ARSA alleles, either known or novel mutations, identified on genetic testing? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or lab results documenting the variant in the ARSA gene.

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. Please indicate which type of mutation was identified:

❒ Known mutations, *Continue to 8*

❒ Novel mutations, *Continue to 7*

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

7. Does the patient have elevated sulfatide levels confirmed by a 24-hour urine collection? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical records, or lab results documenting elevated sulfatide levels based on 24-hour urine collection.

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Has the patient previously received the requested medication or any other gene therapy?

❒ Yes, *No Further Questions*

❒ No, *Continue to 9*

9. Has the patient previously received an allogeneic hematopoietic stem cell transplant (allo-HSCT)?
❒ Yes, *Continue to 10*
❒ No, *No Further Questions*

10. Does the patient have evidence of residual cells of donor origin?
❒ 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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