Luxturna

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 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

Criteria Questions:

1. What is the diagnosis?

❒ Biallelic RPE65 mutation-associated retinal dystrophy, *Continue to 2*

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

2. Is there confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Please indicate which of the following genetic tests was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations. ***ACTION REQUIRED***: Attach genetic test results (single gene test or multi gene panel test) confirming a genetic diagnosis of pathogenic/likely pathogenic biallelic RPE65 gene mutations.

❒ Single gene test ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ Multi gene panel test ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ None of the above*, Continue to 6*

4. Are the RPE65 gene mutations classifications based on the current American College of Medical Genetics and Genomics (ACMG) standards and guidelines for the interpretation of sequence variants?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Please provide the date of the genetic test.

❒ Date. _____ MM/DD/YY, *Continue to 6*

❒ Unknown, *Continue to 6*

6. Has the pathogenic and/or likely pathogenic classification of the RPE65 mutations been affirmed within the last 12 months?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. What is the patient's age?

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

❒ 12 months to 64 years of age, *Continue to 8*

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

8. Which of the following test(s) was performed to confirm that the patient has viable retinal cells in each eye to be treated?

❒ Optical coherence tomography (OCT), *Continue to 9*

❒ Ophthalmoscopy, *Continue to 9*

❒ Optical coherence tomography (OCT) and ophthalmoscopy, *Continue to 9*

❒ None of the above, *Continue to 12*

9. Does the patient have an area of the retina within the posterior pole of greater than 100 micrometer thickness shown on optical coherence tomography (OCT)?

❒ Yes, *Continue to 12*

❒ No, *Continue to 10*

❒ Unknown, *Continue to 10*

10. Within the posterior pole, how many disc areas of the retina are without atrophy or pigmentary degeneration?

❒ 3 or more, *Continue to 12*

❒ Less than 3, *Continue to 11*

❒ Unknown, *Continue to 11*

11. Is the patient's remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 12*

12. Has the patient had the requested drug in the past?

❒ Yes, *Continue to 13*

❒ No, *No Further Questions*

13. Please select the eye which was treated in the past.

❒ Right eye, *Continue to 14*

❒ Left eye, *Continue to 15*

❒ Both eyes, *No Further Questions*

14. Is this request for a right eye treatment?

❒ Yes, right eye, *No Further Questions*

❒ No, left eye, *No Further Questions*

15. Is this request for a left eye treatment?

❒ Yes, left eye, *No Further Questions*

❒ No, right eye, *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

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