Lyfgenia

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

Criteria Questions:

1. What is the diagnosis?

❒ Sickle cell disease, *Continue to #2*

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

2. Is this patient 12 years of age or older?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Does the patient have a confirmed diagnosis of sickle-cell disease? Examples of genotypes include, but not limited to, βS/βS or βS/β0 or βS/β+. ***ACTION REQUIRED****: If Yes, please attach molecular or genetic testing results documenting sickle cell disease genotype*

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Does the patient have more than two α-globin gene deletions?

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. Is the requested medication prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Does the patient have a documented history of at least 2 severe vaso-occlusive episodes (See Appendix A) per year during the previous two years? ***ACTION REQUIRED****: If Yes, please attach the chart notes or medical records documenting history of severe vaso-occlusive episodes*

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Is there a clinically suitable, willing, and available complete or fully HLA matched sibling donor?

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Has the patient received a prior hematopoietic stem cell transplant (HSCT)?

❒ Yes, *Continue to #9*

❒ No, *Continue to #9*

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

❒ Yes, *Continue to #10*

❒ No, *Continue to #10*

10. Does the patient have any prior or current malignancy or immunodeficiency disorder, with the exception of non-melanoma skin cancers OR immediate family member with a known or suspected Familial Cancer Syndrome?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Please indicate the anticipated date of administration of the requested medication

❒ Indicate date of administration: _____, *No Further Questions*

❒ Date unavailable: _____, *No Further Questions*

APPENDIX

Examples of Severe Vaso-Occlusive Events

1. Acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or intravenous [IV] non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions
2. Acute chest syndrome
3. Priapism lasting > 2 hours and requiring a visit to a medical facility
4. Splenic sequestration
5. Hepatic sequestration

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