



Mepsevii

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Mepsevii 2415-A SGM SOC 5413-A – 8/2024.

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Site of Service Questions:

- A. Where will this drug be administered?
- ☐ Ambulatory surgical, *skip to Clinical Criteria Questions*
 - ☐ Home infusion, *skip to Clinical Criteria Questions*
 - ☐ Off-campus Outpatient Hospital, *Continue to B*
 - ☐ On-campus Outpatient Hospital, *Continue to B*
 - ☐ Physician office, *skip to Clinical Criteria Questions*
 - ☐ Pharmacy, *skip to Clinical Criteria Questions*
- B. Is the patient less than 14 years of age?
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to C*
- C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ☐ Yes - This is a continuation of an existing treatment., *Continue to D*
 - ☐ No - This is a new therapy request (patient has not received requested medication in the last 6 months), *skip to Clinical Criteria Questions*
- D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to E*
- E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to F*
- F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to G*
- G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ☐ Yes, *skip to Clinical Criteria Questions*
 - ☐ No, *Continue to H*
- H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) ***greater than*** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ☐ Yes, *continue to Clinical Criteria Questions*
 - ☐ No, *continue to Clinical Criteria Questions*

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Criteria Questions:

1. What is the diagnosis?

☐ Mucopolysaccharidosis VII (MPS VII, Sly syndrome), *Continue to 2*

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

2. Is this a request for continuation of therapy with the requested medication?

☐ Yes, *Continue to 3*

☐ No, *Continue to 4*

3. Has the patient experienced a clinically positive response to therapy, which shall include improvement, stabilization, or slowing of disease progression? ***ACTION REQUIRED:*** If Yes, attach chart note(s) documenting a clinically positive response to therapy, which shall include improvement, stabilization, or slowing of disease progression. ***ACTION REQUIRED:*** Submit supporting documentation

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

4. Was the diagnosis confirmed by enzyme assay demonstrating a deficiency of beta-glucuronidase enzyme activity OR by genetic testing? ***ACTION REQUIRED:*** If Yes, attach beta-glucuronidase enzyme assay or genetic testing results supporting diagnosis. ***ACTION REQUIRED:*** Submit supporting documentation

☐ Yes, *Continue to 5*

☐ No, *Continue to 5*

5. Does the patient have elevated urinary glycosaminoglycan (uGAG) excretion at a minimum of 2-fold over the mean normal for age at initiation of treatment with the requested medication?

☐ 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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