Qfitlia

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

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

Exception Criteria Questions:

A. Is the product being requested for any of the following:
❒ Hemophilia A prophylaxis, *Skip to Clinical Criteria Questions*
❒ Hemophilia B prophylaxis in the presence of Factor IX inhibitors, *Skip to Clinical Criteria Questions*
❒ No, *Continue to Question B*

B. Is the product being requested for Hemophilia B?
❒ Yes, *Continue to Question C*
❒ No, *Skip to Clinical Criteria Questions*

C. Did the patient have a documented inadequate response, contraindication, or intolerable adverse event to all preferred products (Alprolix, Benefix, and Idelvion)? ***ACTION REQUIRED****: If 'Yes', attach supporting chart note(s)*
❒ Yes, *Continue to Clinical Criteria Questions*
❒ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. What is the diagnosis?
❒ Hemophilia A (congenital factor VIII deficiency) -, *Continue to 2*
❒ Hemophilia B (congenital factor IX deficiency), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Will the requested drug be prescribed by or in consultation with a hematologist?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the request for continuation of therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ***ACTION REQUIRED***: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be used in combination with bypassing agents, factor VIII products (e.g., Advate, Adynovate, Eloctate) or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. What is the patient's age?
❒ 12 years of age or older, *Continue to 7*
❒ Less than 12 years of age, *Continue to 7*

7. Does the patient have severe factor VIII (defined as factor VIII level of less than 1%) or severe factor IX (defined as factor IX level of less than or equal to 2%) deficiency? ***ACTION REQUIRED***: If Yes, please attach chart notes, lab tests documenting severe factor VIII (factor VIII level of less than 1%) or severe factor IX (defined as factor IX level of less than 2%) deficiency. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the patient be using the requested drug to treat breakthrough bleeding?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Does the patient have co-existing coagulation disorders (other than hemophilia A or B)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Does the patient have a history of arterial or venous thromboembolism, significant valvular disease or atrial fibrillation, or co-existing thrombophilic disorder (e.g., Factor V Leiden mutation)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have a history of symptomatic gallbladder disease?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have a history of or is planning to undergo immune tolerance treatment?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Please indicate antithrombin (AT) activity at baseline: ***ACTION REQUIRED***: Please attach antithrombin (AT) activity baseline lab results .
❒ Greater than 60 % ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*
❒ Less than 60 % ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*

15. Does the patient have alanine transaminase (ALT) and or aspartate aminotransferase (AST) greater than 1.5 times the upper limit of normal (ULN)? ***ACTION REQUIRED***: If Yes, please attach hematologic assessments. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have clinically significant liver disease? ***ACTION REQUIRED***: If Yes, please attach hepatic assessment. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the requested drug be used in combination with Alhemo, Hemlibra, or Hympavzi?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient previously received treatment with a gene therapy product (e.g., Beqvez, Hemgenix, Roctavian) for the treatment of hemophilia A or hemophilia B?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will prophylactic use of bypassing agents, factor VIII products and factor IX products be discontinued no later than 7 days after the initial dose of the requested drug?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Does the provider attest that AT activity and liver enzymes will be monitored per the protocol outlined in the prescribing information?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug FDA-approved for the medical condition being treated? *If No, No Further Questions*	Yes	No
4. Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days? *If No, Skip to 6*	Yes	No
5. Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition? *If Yes or No*, *No Further Questions*	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? *If Yes, No Further Questions*	Yes	No
7. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? *If Yes, No Further Questions*	Yes	No
9. Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? *No Further Questions*	Yes	No

Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.	Please Circle	
1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
3. Is the alternate drug contraindicated? *If Yes, No Further Questions*	Yes	No
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
5. Has the patient tried the alternate drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? NOTE: Pharmaceutical drug samples are not considered trial and failure of a preferred drug. *If Yes, No Further Questions*	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? *No Further Questions*	Yes	No

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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