



Lucentis, Byooviz, Cimerli, Nufymco, Ranluspec

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 product is being requested? ☐ Lucentis ☐ Byooviz ☐ Cimerli ☐ Nufymco ☐ Ranluspec

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. CareFirst MR Lucentis, Byooviz, Cimerli, Nufymco, Ranluspec C26773-A, SGM 1976-A – 09/2026.

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Exception Criteria Questions: *Skip to Criteria questions if the member is MD Risk*

1. Is the product being requested for the treatment of an ocular disorder?

☐ Yes, *Continue to Question 2*

☐ No, *Skip to Clinical Criteria Questions*

2. The preferred product for your patient's health plan is Avastin. Can the patient's treatment be switched to Avastin?

☐ Yes, *Skip to Clinical Criteria Questions*

☐ No, *Continue to Question 3*

3. Is the patient in an active treatment plan with the requested product?

☐ Yes, *Skip to Clinical Criteria Questions*

☐ No, *Continue to Question 4*

4. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to the preferred product Avastin? **Action Required:** If yes, attach supporting chart note(s)

☐ Yes, *Continue to Clinical Criteria Questions*

☐ No, *Continue to Clinical Criteria Questions*

Clinical Questions:

1. What is the diagnosis?

☐ Diabetic Macular Edema, *Continue to 2*

☐ Neovascular (Wet) Age-Related Macular Degeneration, *Continue to 2*

☐ Macular Edema Following Retinal Vein Occlusion, *Continue to 2*

☐ Diabetic Retinopathy, *Continue to 2*

☐ Myopic Choroidal Neovascularization, *Continue to 2*

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

2. Will the requested drug be prescribed by or in consultation with an ophthalmologist?

☐ Yes, *Continue to 3*

☐ No, *Continue to 3*

3. Is this a request for continuation of therapy?

☐ Yes, *Continue to 4*

☐ No, *No Further Questions*

4. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

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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? <i>If Yes, No Further Questions</i>	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? <i>If Yes, No Further Questions</i>	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. <i>If Yes, No Further Questions</i>	Yes	No
6.	Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? <i>No Further Questions</i>	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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