Reblozyl

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

 Reblozyl SGM 3407-A – 06/2025.

Clinical Criteria:

1. What is the diagnosis?

❒ Anemia associated with beta thalassemia, *Continue to 2*
❒ Anemia associated with hemoglobin E/beta-thalassemia (includes beta-thalassemia with mutation and/or multiplication of alpha globin), *Continue to 2*
❒ Anemia associated with myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm, *Continue to 3*
❒ Myelofibrosis-associated anemia, *Continue to 3*
❒ Other, please specify: _____, *No further questions*

2. Does the patient have a diagnosis of hemoglobin S/beta-thalassemia or alpha-thalassemia?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. Has the patient achieved or maintained a reduction in red blood cell transfusion burden?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Has the patient experienced an unacceptable toxicity while taking the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. What is the diagnosis?

❒ Anemia associated with beta thalassemia, *Continue to 7*
❒ Anemia associated with hemoglobin E/beta-thalassemia (includes beta-thalassemia with mutation and/or multiplication of alpha globin), *Continue to 7*
❒ Anemia associated with myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm, *Continue to 14*
❒ Myelofibrosis-associated anemia, *No further questions*

7. Has the diagnosis of beta thalassemia or hemoglobin E/beta-thalassemia been confirmed by hemoglobin electrophoresis or high-performance liquid chromatography (HPLC), OR molecular genetic testing? ***ACTION REQUIRED***: If Yes, please attach laboratory report or test results.
❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Are there chart notes or medical record documentation stating the patient's diagnosis of beta thalassemia or hemoglobin E/beta-thalassemia was previously confirmed by appropriate testing (e.g., hemoglobin electrophoresis or high-performance liquid chromatography [HPLC], molecular genetic testing)? ***ACTION REQUIRED***: If Yes, please attach supporting documentation.
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Prior to starting treatment with the requested drug, does the patient have symptomatic anemia?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient's pretreatment or pretransfusion hemoglobin (Hgb) level been drawn? ***ACTION REQUIRED***: If Yes, please attach laboratory result or supporting chart note(s) of pretreatment or pretransfusion Hgb level. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. What is the patient's pretreatment or pretransfusion hemoglobin (Hgb) level?

❒ Less than or equal to 11 g/dL, *Continue to 12*

❒ Greater than 11 g/dL, *No further questions*

12. Did the patient require at least 6 red blood cell (RBC) units to be transfused in the previous 24 weeks?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. What is the patient's age?

❒ Less than 18 years of age, *No further questions*

❒ 18 years of age or older, *No further questions*

14. Does the patient have one of the following: A) very low- to intermediate-risk myelodysplastic syndrome, or B) myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Prior to starting treatment with the requested drug, does the patient have symptomatic anemia?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Has the patient's pretreatment or pretransfusion hemoglobin (Hgb) level been drawn? ***ACTION REQUIRED***: If Yes, please attach laboratory result or supporting chart note(s) of pretreatment or pretransfusion Hgb level.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the patient's pretreatment or pretransfusion hemoglobin (Hgb) level?

❒ Less than or equal to 11 g/dL, *Continue to 18*

❒ Greater than 11 g/dL, *Continue to 18*

18. Has the patient been receiving regular red blood cell transfusions as defined by greater than or equal to 2 units per 8 weeks?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. What is the patient's age?

❒ Less than 18 years of age, *No further questions*

❒ 18 years of age or older, *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