Rivfloza

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:** __________________

<u>Referring</u> Provider Info: ❑ Same as Requesting Provider
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: _________________________*kg*

Patient Height: _________________________*cm*

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. Rivfloza 6200-A SGM SOC 6234-A – 1/2026.

Site of Service Questions:

A. Where will this drug be administered?

❑ Ambulatory surgical, *skip to Clinical Questions*
❑ Off-campus Outpatient Hospital, *Continue to B*
❑ Physician office, *skip to Clinical Questions*
❑ Home infusion, *skip to Clinical Questions*
❑ On-campus Outpatient Hospital, *Continue to B*
❑ Pharmacy, *skip to Clinical 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 or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration?
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 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 G*

G. 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*

Clinical Criteria Questions:

1. What is the diagnosis?
❒ Primary hyperoxaluria type (PH1), *Continue to 2*
❒ Other, please specify. _________________________, *Continue to 2*

2. Does the patient have a documented diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by either of the following? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) for molecular genetic tests demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis results demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. a) Molecular genetic test demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene, b) Liver enzyme analysis results demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity.
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Does the patient have a relatively preserved kidney function (e.g., eGFR of greater than or equal to 30 mL/min/1.73 m2)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient 9 years of age or older?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be used in combination with lumasiran?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 7*
❒ No, *No Further Questions*

7. Does the patient demonstrate a positive response to therapy (e.g., decrease or normalization in urinary and/or plasma oxalate levels, improvement in kidney function)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical records demonstrating a positive response to therapy.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *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)**