Ryzneuta

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

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Criteria Questions:

1. What is the patient's diagnosis?
❒ Neutropenia associated with myelosuppressive anti-cancer therapy, *Continue to 4*
❒ Stem cell transplantation-related indication, *No further questions*
❒ Hematopoietic acute radiation syndrome, *Continue to 2*
❒ Hairy cell leukemia, *Continue to 3*
❒ Other, please specify. _____, *No further questions*

2. Will the requested drug be used for the treatment of radiation-induced myelosuppression following a radiological/nuclear incident?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

3. Will the requested drug be used for treatment of neutropenic fever following chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. Will the requested drug be used in combination with any other colony stimulating factor products within any chemotherapy cycle?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the patient be receiving chemotherapy at the same time as they receive radiation therapy?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Will the requested drug be administered with a weekly chemotherapy regimen?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. For which of the following indications is the requested drug being prescribed?
❒ Primary prophylaxis (i.e., to be given 24 hours after first cycle of chemotherapy) of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancy, *Continue to 8*
❒ Secondary prophylaxis of febrile neutropenia in a patient with a solid tumor or non-myeloid malignancies, *Continue to 15*
❒ Other, please specify. _____, *No further questions*

8. Has the patient recently received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in greater than 20% incidence of febrile neutropenia? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 9*

9. Has the patient recently received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in 10-20% risk of febrile neutropenia? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 11*
❒ No, *Continue to 10*

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10. Has the patient recently received, is currently receiving, or will be receiving myelosuppressive anti-cancer therapy that is expected to result in less than 10% risk incidence of febrile neutropenia? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's diagnosis and the chemotherapeutic regimen. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

11. Is the patient considered to be at high risk for febrile neutropenia because of bone marrow compromise, co-morbidities, or other patient specific risk factors including any of the following? ***ACTION REQUIRED***: If Yes, please submit documentation confirming the patient's risk factors.
❒ Yes, active infections, open wounds, or recent surgery ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, age greater than or equal to 65 years ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, bone marrow involvement by tumor producing cytopenias ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, previous chemotherapy or radiation therapy ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, poor nutritional status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, poor performance status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, previous episodes of FN ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease. Please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, persistent neutropenia ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Yes, other bone marrow compromise, comorbidities, or patient specific risk factors not listed above. Please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, the patient does not have any risk factors, *No further questions*

12. Please indicate which risk factor applies to the patient: ***ACTION REQUIRED***: Please submit documentation confirming the patient's risk factors.
❒ Active infections, open wounds, or recent surgery ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Age greater than or equal to 65 years ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Bone marrow involvement by tumor producing cytopenias ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Previous chemotherapy or radiation therapy ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Poor nutritional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Poor performance status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Previous episodes of FN ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Persistent neutropenia ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ None of the above, *Continue to 13*

13. Does the patient have a second risk factor?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Please indicate the patient's second risk factor: ***ACTION REQUIRED***: Please submit documentation confirming the patient's risk factors.
❒ Active infections, open wounds, or recent surgery ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Age greater than or equal to 65 years ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Bone marrow involvement by tumor producing cytopenias ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Previous chemotherapy or radiation therapy ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Poor nutritional status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Poor performance status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Previous episodes of FN ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Other serious co-morbidities, including renal dysfunction, liver dysfunction, HIV infection, cardiovascular disease. Please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Persistent neutropenia ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ The patient does not have a second risk factor, *No further questions*

15. Has the patient experienced a febrile neutropenic complication or a dose-limiting neutropenic event (a nadir or day of treatment count impacting the planned dose of chemotherapy) from a prior cycle of similar chemotherapy?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. For the planned chemotherapy cycle, will the patient receive the same dose and schedule of chemotherapy as the previous cycle (for which primary prophylaxis was not received)?
❒ 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)**

