Skysona

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*

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Cerebral adrenoleukodystrophy (CALD), *Continue to 2*

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

2. Is the patient male?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. What is the patient's age (in years)?

❒ Under 4 years of age, *Continue to 4*

❒ Between 4 and 17 years of age, *Continue to 4*

❒ Over 17 years of age, *Continue to 4*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

4. Will the requested medication be prescribed by or in consultation with a prescriber who specializes in the treatment of adrenoleukodystrophy (ALD)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be used to treat or prevent adrenal insufficiency?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient have cerebral adrenoleukodystrophy (CALD) secondary to head trauma?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have full deletions of the ABCD1 transgene as detected by genetic testing?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have a pathogenic (or likely pathogenic) variant in the ABCD1 gene as detected by genetic testing? ***ACTION REQUIRED***: If Yes, attach chart notes, medical records or lab results supporting a pathogenic (or likely pathogenic) variant in the ABCD1 gene.
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have elevated very long chain fatty acids (VLCFA) values per reference range of the laboratory performing the test? ***ACTION REQUIRED***: If Yes, attach chart notes, medical records or lab results supporting elevated very long chain fatty acids (VLCFA) values.
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient had a central radiographic review of brain magnetic resonance imaging (MRI) demonstrating early active central nervous system (CNS) disease with a Loes score between 0.5 and 9 (inclusive) on the 34-point scale? ***ACTION REQUIRED***: If Yes, attach chart notes, medical records or test results supporting active CNS disease on brain MRI and Loes score between 0.5 and 9 (inclusive) on the 34-point scale.
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient had a central radiographic review of brain magnetic resonance imaging (MRI) demonstrating early active central nervous system (CNS) disease with gadolinium enhancement of demyelinating lesions? ***ACTION REQUIRED***: If Yes, attach chart notes, medical records or test results supporting gadolinium enhancement on MRI of demyelinating lesions.
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have a Neurologic Function Score (NFS) of less than or equal to 1? ***ACTION REQUIRED***: If Yes, attach chart notes, medical records or test results supporting Neurologic Function Score (NFS) less than or equal to 1
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient eligible for a hematopoietic stem cell transplant (HSCT) but is unable to find a matched sibling donor?

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
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❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient previously received the requested drug or any other gene therapy?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Has the patient received a prior allogeneic hematopoietic stem cell transplant (allo-HSCT)?
❒ 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)**

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