



## Somavert

### 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](mailto: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**

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 Somavert SGM 2097-A – 04/2025.

**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](http://www.caremark.com)**

**Criteria Questions:**

1. What is the diagnosis?

☐ Acromegaly, *Continue to 2*

☐ Other, please specify. \_\_\_\_\_, *Continue to 2*

2. Is the patient currently on therapy with the requested drug?

☐ Yes, *Continue to 6*

☐ No, *Continue to 3*

3. How does the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender? ***ACTION REQUIRED:*** Attach laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level.

☐ IGF-1 level is higher than the laboratory's normal range ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 4*

☐ IGF-1 level is lower than the laboratory's normal range ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 4*

☐ IGF-1 level falls within the laboratory's normal range ***ACTION REQUIRED:*** *Submit supporting documentation, Continue to 4*

4. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED:*** If Yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery or radiotherapy.

☐ Yes, *No Further Questions*

☐ No, *Continue to 5*

5. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED:*** If Yes, attach supporting chart note(s) indicating a clinical reason for not having surgery or radiotherapy.

☐ Yes, *No Further Questions*

☐ No, *No Further Questions*

6. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy? ***ACTION REQUIRED:*** If decreased or normalized, attach laboratory report indicating normal current IGF-1 levels or chart note(s) indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.

☐ Increased, *No further questions*

☐ Decreased or normalized ***ACTION REQUIRED:*** *Submit supporting documentation, No further questions*

☐ No change, *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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