Stimate

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

Criteria Questions:

1. What is the patient's diagnosis?

❒ von Willebrand disease (VWD), *Continue to 2*

❒ Hemophilia A, *Continue to 2*

❒ Qualitative platelet disorder, *Continue to 2*

❒ Acquired hemophilia A, *Continue to 2*

❒ Acquired von Willebrand syndrome (AVWS), *Continue to 2*

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

2. Is the request for continuation of therapy?

❒ Yes, *Continue to 7*

❒ No, *Continue to 3*

3. What is the patient's diagnosis?

❒ von Willebrand disease (VWD), *Continue to 4*

❒ Hemophilia A, *Continue to 6*

❒ Qualitative platelet disorder, *No further questions*

❒ Acquired hemophilia A, *No further questions*

❒ Acquired von Willebrand syndrome (AVWS), *No further questions*

4. What type of von Willebrand disease does the patient have?

❒ Type 1, *Continue to 5*

❒ Type 2A, *No further questions*

❒ Type 2B, *No further questions*

❒ Type 2M, *No further questions*

❒ Type 2N, *No further questions*

❒ Type 3, *No further questions*

❒ Other, please specify. _____, *No further questions*

5. Does the patient have mild or moderate disease?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. What is the patient's baseline factor VIII activity level?

❒ Greater than 5%, *No further questions*

❒ Less than or equal to 5%, *No further questions*

7. What is the patient's diagnosis?

❒ von Willebrand disease (VWD), *Continue to 9*

❒ Hemophilia A, *Continue to 8*

❒ Qualitative platelet disorder, *Continue to 8*

❒ Acquired hemophilia A, *Continue to 8*

❒ Acquired von Willebrand syndrome (AVWS), *Continue to 8*

8. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

9. What type of von Willebrand disease does the patient have?

❒ Type 1, *Continue to 10*

❒ Type 2A, *Continue to 11*

❒ Type 2M, *Continue to 11*

❒ Type 2N, *Continue to 11*

10. Does the patient have mild or moderate disease?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. How long has the patient received therapy with the requested drug?

❒ Greater than or equal to 12 months, *Continue to 13*

❒ Less than 12 months, *Continue to 12*

12. Has the patient been shown to be responsive to an initial trial of the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

13. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?

❒ 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)**

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