Triptodur

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

 Triptodur WITH Other Indications 2504-A SGM 06/2025..

Criteria Questions:

1. What is the diagnosis?

❒ Central precocious puberty (CPP), *Continue to 2*

❒ Gender dysphoria, *Continue to 13*

❒ Preservation of ovarian function, *Continue to 22*

❒ Recurrent menstrual related attacks in acute porphyria, *Continue to 23*

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

2. Is the patient currently receiving the prescribed therapy for central precocious puberty (CPP) through a paid pharmacy or medical benefit?

❒ Yes, *Continue to 3*

❒ No, *Continue to 7*

3. Is the patient experiencing signs of treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. What is the patient's gender?

❒ Male, *Continue to 5*

❒ Female, *Continue to 6*

5. What is the patient's age?

❒ Less than 13 years of age, *No further questions*

❒ 13 years of age or older, *No further questions*

6. What is the patient's age?

❒ Less than 12 years of age, *No further questions*

❒ 12 years of age or older, *No further questions*

7. Has the diagnosis of central precocious puberty been confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay? ***ACTION REQUIRED***: If Yes, collect laboratory report or medical record of pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay.

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty (CPP)?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. What is the patient's gender?

❒ Male, *Continue to 10*

❒ Female, *Continue to 11*

10. How old was the patient at the onset of secondary sexual characteristics?

❒ Less than 9 years of age, *Continue to 12*

❒ 9 years of age or older, *Continue to 12*

11. How old was the patient at the onset of secondary sexual characteristics?

❒ Less than 8 years of age, *Continue to 12*

❒ 8 years of age or older, *Continue to 12*

12. Has the pathologic cause of central precocious puberty (CPP) been assessed? (e.g., imaging screening for intracranial tumors, genetic testing for familial CPP [e.g., MKRN3 or DLK1 mutations])?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Is the patient less than 18 years of age?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the patient undergoing gender transition?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Will the patient receive the requested drug concomitantly with gender-affirming hormones?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the patient able to make an informed decision to engage in treatment?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the request for continuation of therapy?
❒ Yes, *Continue to 21*
❒ No, *Continue to 20*

20. Has the patient been informed of fertility preservation options?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Is the patient premenopausal and undergoing chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Is the requested drug being requested to prevent recurrent menstrual related attacks in acute porphyria?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the requested drug prescribed by, or in consultation with, a provider experienced in the management of porphyrias?
❒ 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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