Waskyra

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

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.

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

Criteria Questions:

1. What is the diagnosis?
❒ Wiskott-Aldrich Syndrome (classic WAS), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Will the requested drug be prescribed by or in consultation with an immunologist, hematologist, or physician who specializes in the treatment of Wiskott-Aldrich Syndrome (classic WAS)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. What is the patient's age?
❒ Less than 6 months of age, *Continue to 4*
❒ 6 months of age or older, *Continue to 4*

4. Has the diagnosis been confirmed by the presence of a pathogenic variant in the WAS gene? ***ACTION REQUIRED***: If Yes, attach genetic testing results demonstrating a pathogenic variant in the WAS gene. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have absent or truncated Wiskott-Aldrich Syndrome protein (WASP) expression assessed by flow cytometry? ***ACTION REQUIRED***: If Yes, attach flow cytometry lab results showing level of Wiskott-Aldrich Syndrome Protein (WASP) expression. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 7*
❒ No, *Continue to 6*

6. Does the patient have a severe clinical phenotype (Zhu clinical score greater than or equal to 3)? ***ACTION REQUIRED***: If Yes, attach chart notes or medical records of Zhu clinical score confirming a severe clinical phenotype (score greater than or equal to 3, refer to criteria, Appendix A: WAS-Related Disorders: Clinical Scoring System) ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the patient an appropriate candidate for hematopoietic stem cell transplant (HSCT)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the age of the patient?
❒ Less than 5 years of age, *Continue to 10*
❒ 5 years of age or older, *Continue to 9*

9. Does the patient have a human leukocyte antigen (HLA)-identical sibling donor?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

10. Does the patient have an HLA-identical sibling donor, suitable 10/10 HLA matched unrelated donor, or 6/6 HLA matched unrelated cord blood donor?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

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 Waskyra SGM 7334-A – 10/2026.

11. Has the patient received a prior allogeneic hematopoietic stem cell transplant (allo-HSCT)?
❒ Yes, the patient has received a prior HSCT but not in the past 6 months, *Continue to 12*
❒ Yes, the patient has received a prior HSCT in the past 6 months, *Continue to 12*
❒ No, *Continue to 13*

12. Does the patient have evidence of residual cells of donor origin?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient negative for human immunodeficiency virus (HIV) and hepatitis C infection?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Does the patient have acute or chronic stable hepatitis B?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Does the patient have symptomatic herpes zoster that is unresponsive to specific treatment?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Does the patient have evidence of acute tuberculosis?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has malignant neoplasia (except local skin cancer) affected the patient?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Does the patient have a documented history of hereditary cancer syndrome?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Has the patient been affected by cytogenic alterations typical of myelodysplastic syndrome or acute myelogenous leukemia?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Has the patient been affected by end-organ dysfunction, severe active infection, or any other severe disease that, in the opinion of the provider, would make the patient an inappropriate candidate for treatment with the requested drug?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Will the patient be assessed and monitored for evidence of engraftment failure, cytopenia, infection, hepatic veno-occlusive disease, and malignancies as outlined in the manufacturer's prescribing information?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Has the patient previously received the requested drug or any other gene therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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 Waskyra SGM 7334-A – 10/2026.

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

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 Waskyra SGM 7334-A – 10/2026.