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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 diagnosis?

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

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

❒ Hemophilia A, *Continue to 2*

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

2. Will the requested medication be prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the request for continuation of therapy?

❒ Yes, *Continue to 13*

❒ No, *Continue to 4*

4. What is the diagnosis?

❒ von Willebrand disease (VWD), *Continue to 5*

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

❒ Hemophilia A, *Continue to 9*

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

❒ Type 1, *Continue to 6*

❒ Type 2A, *Continue to 6*

❒ Type 2B, *No further questions*

❒ Type 2M, *Continue to 6*

❒ Type 2N, *Continue to 6*

❒ Type 3, *No further questions*

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

6. Has the patient had an insufficient response to desmopressin?

❒ Yes, *No Further Questions*

❒ No, *Continue to 7*

7. Is there a clinical reason for not trying desmopressin first?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. What is the reason? Please document the clinical reason for not trying desmopressin first.

❒ Age less than 2 years, *No further questions*

❒ Pregnancy, *No further questions*

❒ Fluid/electrolyte imbalance, *No further questions*

❒ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No further questions*

❒ Predisposition to thrombus formation, *No further questions*

❒ Trauma requiring surgery, *No further questions*

❒ Life-threatening bleed, *No further questions*

❒ Contraindication or intolerance to desmopressin, *No further questions*

❒ Severe type 1 von Willebrand disease, *No further questions*

❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No further questions*

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

9. What is the patient's baseline factor VIII assay level (% activity)?

❒ Less than 1% to 5% (moderate or severe disease), *No further questions*

❒ Greater than 5% (mild disease), *Continue to 10*

10. Has the patient had an insufficient response to desmopressin?

❒ Yes, *No Further Questions*

❒ No, *Continue to 11*

11. Is there a clinical reason for not trying desmopressin first?

❒ Yes, *Continue to 12*

❒ No, *Continue to 12*

12. What is the reason? Please indicate the clinical reason for not trying desmopressin first.

❒ Age less than 2 years, *No further questions*

❒ Pregnancy, *No further questions*

❒ Fluid/electrolyte imbalance, *No further questions*

❒ High risk for cardiovascular or cerebrovascular disease (especially elderly), *No further questions*

❒ Predisposition to thrombus formation, *No further questions*

❒ Trauma requiring surgery, *No further questions*

❒ Life-threatening bleed, *No further questions*

❒ Contraindication or intolerance to desmopressin, *No further questions*

❒ Severe type 1 von Willebrand disease, *No further questions*

❒ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable), *No further questions*

❒ Other, please specify. _____, *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)**

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