CVS/caremark™

Winrevair
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? _____

Criteria Questions:

1. What is the diagnosis?

❐ Pulmonary arterial hypertension (PAH), *Continue to 2*

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

2. Is the requested drug prescribed by or in consultation with a pulmonologist or cardiologist?
❐ Yes, *Continue to 3*
❐ No, *Continue to 3*

3. Is the patient currently receiving treatment with the requested drug?
❐ Yes, *Continue to 4*
❐ No, *Continue to 6*

4. Is the patient currently receiving the requested drug through a paid pharmacy or medical benefit?

❐ Yes, *Continue to 5*

❐ No, *Continue to 6*

❐ Unknown, *Continue to 6*

5. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement?
❐ Yes, *No Further Questions*
❐ No, *No Further Questions*

6. What is the World Health Organization (WHO) classification of pulmonary hypertension?

❐ WHO Group 1 (Pulmonary arterial hypertension), *Continue to 7*

❐ WHO Group 2 (Pulmonary hypertension associated with left heart disease), *Continue to 7*

❐ WHO Group 3 (Pulmonary hypertension associated with lung diseases and/or hypoxia), *Continue to 7*

❐ WHO Group 4 (Pulmonary hypertension associated with pulmonary artery obstructions), *Continue to 7*

❐ WHO Group 5 (Pulmonary hypertension with unclear and/or multifactorial mechanisms), *Continue to 7*

7. Has the diagnosis been confirmed by right heart catheterization?
❐ Yes, *Continue to 8*
❐ No, *Continue to 8*

8. What was the pretreatment (before any pulmonary arterial hypertension [PAH] therapy) mean pulmonary arterial pressure (mPAP)?

❐ Greater than 20 mmHg, *Continue to 9*

❐ Less than or equal to 20 mmHg, *Continue to 9*

9. What was the pretreatment (before any pulmonary arterial hypertension [PAH] therapy) pulmonary capillary wedge pressure (PCWP)?

❐ Less than or equal to 15 mmHg, *Continue to 10*

❐ Greater than 15 mmHg, *Continue to 10*

10. What was the pretreatment (before any pulmonary arterial hypertension [PAH] therapy) pulmonary vascular resistance (PVR) while stable on at least two pulmonary arterial hypertension (PAH) drugs?

❏ Greater than 2 Wood units, *Continue to 11*

❏ Less than or equal to 2 Wood units, *Continue to 11*

11. Will the requested drug be used as add-on therapy?
❏ Yes, *Continue to 12*
❏ No, *Continue to 12*

12. Is the patient currently receiving pulmonary arterial hypertension (PAH) therapy with drugs from at least two of the following drug classes: A) Endothelin receptor antagonist (e.g., Letairis, Opsumit, Tracleer), B) Phosphodiesterase-5 inhibitor (e.g., Adcirca, Revatio), C) Soluble guanylate cyclase stimulator (e.g., Adempas), D) Prostacyclin analog (e.g., Flolan, Orenitram, Remodulin, Tyvaso, Veletri, Ventavis), or E) Prostacyclin receptor agonist (e.g., Uptravi)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting current PAH therapy.
❏ Yes, *Continue to 13*
❏ No, *Continue to 13*

13. Is the patient 18 years of age or older?
❏ 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)**