Yartemlea

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

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 patient's diagnosis?
❒ Hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Will the requested medication be used in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or Defitelio (defibrotide)?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

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

4. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the patient experiencing a positive response to therapy (e.g., improvement in platelet levels, normalization of lactate dehydrogenase [LDH] and haptoglobin levels)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or medical record documentation supporting positive clinical response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Is the patient 2 years of age or older?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Does the patient have a platelet count of less than 150,000/microL? ***ACTION REQUIRED***: If Yes, attach chart notes or test results documenting platelet count results.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*
❒ No, *Continue to 8*
❒ Unknown, *Continue to 8*

8. Is there evidence of microangiopathic hemolysis (presence of schistocytes, serum LDH greater than the upper limit of normal [ULN] and/or haptoglobin less than the lower limit of normal [LLN])? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming evidence of microangiopathic hemolysis.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*
❒ No, *Continue to 9*
❒ Unknown, *Continue to 9*

9. What is the patient's ADAMTS13 activity level? ***ACTION REQUIRED***: If 10% or greater, attach chart note(s) or test results of an ADAMTS13 level.
❒ Less than 10%, *No further questions*
❒ 10% or greater ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *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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