



## Eylea, Eylea HD and biosimilars

### 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](mailto: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: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Specialty: \_\_\_\_\_ 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. Eylea-Eylea HD and Biosimilars SGM 2024-A – 01/2025.

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](http://www.caremark.com)

**Criteria Questions:**

1. Please indicate which of the following drugs this request is for?

- ☐ Ahzantive, *Continue to 2*
- ☐ Enzeevu, *Continue to 2*
- ☐ Eylea, *Continue to 2*
- ☐ Eylea HD, *Continue to 3*
- ☐ Opuviz, *Continue to 2*
- ☐ Pavblu, *Continue to 2*
- ☐ Yesafili, *Continue to 2*

2. What is the diagnosis?

- ☐ Diabetic Macular Edema, *Continue to 4*
- ☐ Diabetic Retinopathy, *Continue to 4*
- ☐ Neovascular (Wet) Age-Related Macular Degeneration, *Continue to 4*
- ☐ Macular Edema Following Retinal Vein Occlusion, *Continue to 4*
- ☐ Retinopathy of Prematurity, *Continue to 4*
- ☐ Other, please specify. \_\_\_\_\_, *Continue to 4*

3. What is the diagnosis?

- ☐ Diabetic Macular Edema, *Continue to 4*
- ☐ Diabetic Retinopathy, *Continue to 4*
- ☐ Neovascular (Wet) Age-Related Macular Degeneration, *Continue to 4*
- ☐ Other, please specify. \_\_\_\_\_, *Continue to 4*

4. Is this a request for continuation of therapy?

- ☐ Yes, *Continue to 5*
- ☐ No, *No Further Questions*

5. Has the patient demonstrated a positive clinical response to therapy (e.g., improvement or maintenance in best corrected visual acuity [BCVA] or visual field, or a reduction in the rate of vision decline or the risk of more severe vision loss)?

- ☐ 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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