Zynteglo

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? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Transfusion-dependent beta-thalassemia, *Continue to #2*

❒ Other, *Continue to #2*

2. Has genetic testing been done to confirm the genotype? ***Action Required***: If 'Yes', attach molecular or genetic testing results documenting transfusion-dependent beta-thalassemia genotype

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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3. Does the patient have a non-beta-0/beta-0 OR beta-0/beta-0 genotype confirmed via genetic testing? Note: See Appendix A for examples of non-β0/β0 OR β0/β0 genotypes

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Does the patient require regular blood cell transfusions?

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. In the past two years, has the patient received at least 100 milliliter per kilogram of packed red blood cells (pRBCs) per year? ***Action Required***: If 'Yes', attach chart notes or medical record documenting history of blood cell transfusions for the previous two years

❒ Yes, *Continue to #7*

❒ No, *Continue to #6*

6. In the past two years, has the patient received at least 8 transfusions events of packed red blood cells (pRBCs) per year? ***Action Required***: If 'Yes', attach chart notes or medical record documenting history of blood cell transfusions for the previous two years

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Is the patient clinically stable and eligible for a hematopoietic stem cell transplant (HSCT) but is unable to find a matched related donor?

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Has the patient received a prior hematopoietic stem cell transplant (HSCT)?

❒ Yes, *Continue to #9*

❒ No, *Continue to #9*

9. Has the patient previously received the requested medication or any other gene therapy?

❒ Yes, *Continue to #10*

❒ No, *Continue to #10*

10. What is the patient's age at time of treatment decision?

_____months _____years, *Continue to #11*

11. What is the patient's weight?

_____kg, *Continue to #12*

12. Is the patient reasonably anticipated to provide at least the minimum number of cells required to initiate the manufacturing process?

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

13. Is the requested medication prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to #14*

❒ No, *Continue to #14*

14. Does the patient have any of the following conditions?
❒ Yes - Positive for the presence of human immunodeficiency virus type 1 or 2 (HIV-1 and HIV-2), hepatitis B virus (HBV), or hepatitis C (HCV), *No Further Questions*

❒ Yes - Any prior or current malignancy, *No Further Questions*

❒ Yes - Advanced liver disease (e.g., bridging fibrosis, cirrhosis, active hepatitis), *No Further Questions*
❒ Yes - Severely elevated iron in the heart (i.e., patients with cardiac T2* less than 10 msec by MRI), *No Further Questions*

❒ Yes - Severe iron overload that, in physician's opinion, warrants exclusion, *No Further Questions*
❒ Yes - A white blood cell (WBC) count <3×10^9/L, and/or platelet count <100×10^9/L not related to hypersplenism., *No Further Questions*

❒ Yes - Uncorrected bleeding disorder, *No Further Questions*
❒ Yes – An available human leukocyte antigen- identical or human leukocyte antigen- matched donor, *No Further Questions*

❒ None of the above, *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)**

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