# Remodulin, treprostinil

## 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**

 CareFirst MR C26682-A Remodulin SGM 1644-A – 1/2025.

**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**

**Exception Criteria Questions:**

A. Is the product being requested for a patient with pulmonary arterial hypertension?

❒ Yes, *Continue to Question B*

❒ No, *Skip to Criteria Questions*

B. What is the prescribed product?

❒ Treprostinil (generic), *Skip to Criteria Questions.*

❒ Remodulin, *Continue to Question C*

C. The preferred product for your patient's health plan is treprostinil intravenous injection (generic).

Can the patient's treatment be switched to the preferred product?

❒ Yes, *Skip to Criteria Questions*

❒ No, *Continue to Question D*

D. Does the patient have a documented intolerable adverse event to the preferred product (treprostinil)? ***Action Required***: If 'Yes', attach supporting chart note(s).

❒ Yes, *Continue to Question E*

❒ No, *Continue to Question F*

E. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***Action Required***: If 'Yes', attach supporting chart note(s).

❒ Yes, *Continue to Question F*

❒ No, *Skip to Criteria Questions*

F. Does the patient have a documented inadequate response to the preferred product (treprostinil)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Skip to Criteria Questions*

❒ No, *Continue to Question G*

G. Does the patient have a contraindication to the preferred product (treprostinil)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Criteria Questions*

❒ No, *Continue to Criteria Questions*

**Criteria Questions:**

1. What is the diagnosis?

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

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

2. Is the requested medication 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 medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 6*

4. Is the patient currently receiving the requested medication through a paid pharmacy or medical benefit?
Tech Note: If Yes, please review past 120 days in claim history for paid claim. If no paid claim found, 'yes' can be accepted when the following is confirmed: 1) patient is within 120 days of eligibility start date, 2) there is no evidence of preceding line of eligibility, and 3) the provider attests prior coverage under insured benefit.

❒ Yes, *Continue to 5*

❒ No, *Continue to 6*

❒ Unknown, *Continue to 6*

5. Is the patient experiencing benefit from therapy 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 owing to left heart disease), *Continue to 7*

❒ WHO Group 3 (Pulmonary hypertension owing to lung disease and/or hypoxia), *Continue to 7*

❒ WHO Group 4 (Pulmonary hypertension owing to pulmonary artery obstruction), *Continue to 7*

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

7. Has the diagnosis been confirmed by pretreatment right heart catheterization?
❒ Yes, *Continue to 8*
❒ No, *Continue to 13*

8. What is the pretreatment mean pulmonary arterial pressure (mPAP)?

❒ Greater than 20 mmHg, *Continue to 9*

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

9. What is the pretreatment pulmonary capillary wedge pressure (PCWP)?

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

❒ Greater than 15 mmHg, *Continue to 10*

10. Is the patient less than 18 years of age?
❒ Yes, *Continue to 12*
❒ No, *Continue to 11*

11. What is the pretreatment pulmonary vascular resistance (PVR)?

❒ Greater than or equal to 3 Wood units, *No further questions*

❒ Less than 3 Wood units, *No further questions*

12. What is the pretreatment pulmonary vascular resistance index (PVRI)? (Note: m2 represents unit of body surface area, meters squared)

❒ Greater than or equal to 3 Wood units x m2, *No further questions*

❒ Less than 3 Wood units x m2, *No further questions*

13. Is the patient an infant less than one year of age?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has Doppler echocardiogram been performed to confirm the diagnosis?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

| **Step Therapy Override: Complete if Applicable for the state of Maryland.** | Please Circle | |
|---|---|---|
| Is the requested drug being used to treat stage four advanced metastatic cancer? | Yes | No |
| Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature? | Yes | No |
| Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? | Yes | No |
| Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? | Yes | No |
| Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days? | Yes | No |
| Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition? | Yes | No |

| **Step Therapy Override: Complete if Applicable for the state of Virginia.** | Please Circle | |
|---|---|---|
| Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? | Yes | No |
| Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? | Yes | No |
| Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available? | Yes | No |
| Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient? | Yes | No |
| Is the preferred drug contraindicated? | Yes | No |
| Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? | Yes | No |

| | | |
|---|---|---|
| Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? | Yes | No |
| Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? | Yes | No |

***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**



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