PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

**Patient Name:** _____ **Date:** 3/31/2025
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**
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**Drug Name (specify drug)** _____

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____
_____
_____

**Please check the appropriate answer for each applicable question.**

1. What is the diagnosis?
   - Hemophilia A (congenital factor VIII deficiency) (If checked, go to 2) ☐
   - Hemophilia B (congenital factor IX deficiency) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the requested drug be prescribed by or in consultation with a hematologist? **Y** ☐ **N** ☐

3. Is the request for continuation of therapy? **Y** ☐ **N** ☐

4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ACTION REQUIRED: If Yes, please attach chart notes documenting benefit from therapy (e.g., reduced frequency or severity of bleeds). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Will the requested drug be used in combination with bypassing agents (e.g., FEIBA, NovoSeven), factor VIII products (e.g., Advate, Adynovate, Eloctate), or factor IX products (e.g., Alprolix, Ixinity, Rebinyn) for prophylactic use? **Y** ☐ **N** ☐

6. What is the patient's age?
   - 12 years of age or older (If checked, go to 7) ☐
   - Less than 12 years of age (If checked, no further questions) ☐

7. Is the patient's weight greater than 25 kg? **Y** ☐ **N** ☐

8. Does the patient have a documented history of factor VIII or factor IX inhibitors (greater than or equal to 0.6 Bethesda units [BU])? ACTION REQUIRED: If Yes, please attach chart notes, lab tests confirming factor VIII or factor IX inhibitors. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Is the requested drug being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? **Y** ☐ **N** ☐

10. Has the patient been prescribed, or in need of, treatment with a bypassing agent within the past 6 months (e.g., FEIBA, NovoSeven)? **Y** ☐ **N** ☐

11. Does the patient have a history, current signs or symptoms, or is at high risk of thromboembolic events? **Y** ☐ **N** ☐

12. Is the patient currently undergoing or is planning to undergo immune tolerance treatment? **Y** ☐ **N** ☐

13. Does the patient have a platelet count of less than 100,000 cells/microL at baseline? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting baseline platelet count.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

14. Does the patient have an alanine transaminase (ALT) and/or aspartate aminotransferase (AST) greater than 3 times the upper limit of normal (ULN) at baseline? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting baseline liver function tests.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

15. Does the patient have a total bilirubin level greater than 1.5 times ULN (unless there is a diagnosis of Gilbert's Syndrome and the patient is otherwise stable) at baseline? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting baseline total bilirubin level.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

16. Does the patient have a fibrinogen level below the laboratory lower limit of normal at baseline? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting baseline fibrinogen level.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

17. Does the patient have an estimated glomerular filtration rate (eGFR) less than or equal to 30 mL/min/1.73 m^2? ACTION REQUIRED: If No, please attach chart notes, lab tests documenting baseline eGFR rate.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

18. Will the requested drug be used in combination with Hemlibra? **Y** ☐ **N** ☐

19. Has the patient previously received treatment with a gene therapy product (e.g., Beqvez, Hemgenix, Roctavian) for the treatment of hemophilia A or B? **Y** ☐ **N** ☐

20. Will prophylactic use of bypassing agents, factor VIII products ( e.g., Advate, Adynovate, Eloctate), and factor IX products (e.g., Alprolix, Ixinity, Rebinyn) be discontinued prior to starting therapy with the requested drug? **Y** ☐ **N** ☐

21. Does the provider attest that concizumab-mtci plasma concentrations will be monitored per the protocol outlined in the prescribing information? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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**Prescriber (Or Authorized) Signature and Date**