Endari

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Sickle Cell Disease
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is Endari being requested for use in reducing the acute complications of sickle cell disease? ❑ Yes ❑ No
4. Is Endari being prescribed by or in consultation with a hematologist or specialist in sickle cell disease?
   ❑ Yes ❑ No
5. Is this request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #7*
6. Has the patient experienced a reduction in acute complications of sickle cell disease (e.g., reduction in the number of painful vaso-occlusive episodes, acute chest syndrome episodes, fever, occurrences of priapism, splenic sequestration) since initiating therapy with the requested drug? ❑ Yes ❑ No *No further questions.*
7. What is the patient's sickle cell genotype?
   ❑ Homozygous hemoglobin S (HbSS)
   ❑ Sickle hemoglobin C (HbSC), *no further questions.*
   ❑ Sickle beta0-thalassemia (HbSbeta0)
   ❑ Sickle beta+-thalassemia (HbSbeta+), *no further questions.*
   ❑ Other/Unknown
8. Has the patient experienced, at any time in the past, an inadequate response or intolerance to a trial of hydroxyurea? *If Yes, no further questions.* ❑ Yes, inadequate response ❑ Yes, intolerance ❑ No
9. Does the patient have a contraindication to hydroxyurea? *If Yes, no further questions.* ❑ Yes ❑ No
10. Will the patient be using Endari with concurrent hydroxyurea therapy? ❑ 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 Prior Authorization Fax: 1-866-249-6155