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:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

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) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the requested medication 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, attach supporting chart note(s) documenting benefit from therapy (e.g., reduced frequency or severity of bleeds). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Will the patient use the requested medication in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.) for prophylactic use? **Y** ☐ **N** ☐

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

7. What is the patient's baseline factor VIII assay level (% activity)?
   - Less than 1% to 5% (moderate or severe disease) (If checked, go to 13) ☐
   - Greater than 5% (mild disease) (If checked, go to 8) ☐

8. Has the patient had an insufficient response to desmopressin? **Y** ☐ **N** ☐

9. Is there a clinical reason for not trying desmopressin first? **Y** ☐ **N** ☐

10. What is the reason? Please indicate the clinical reason for not trying desmopressin first.
    - Age less than 2 years (If checked, go to 11) ☐
    - Pregnancy (If checked, go to 11) ☐
    - Fluid/electrolyte imbalance (If checked, go to 11) ☐
    - High risk for cardiovascular or cerebrovascular disease (especially the elderly) (If checked, go to 11) ☐

Predisposition to thrombus formation (If checked, go to 11) ☐

Trauma requiring surgery (If checked, go to 11) ☐

Life-threatening bleed (If checked, go to 11) ☐

Contraindication or intolerance to desmopressin (If checked, go to 11) ☐

Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable) (If checked, go to 11) ☐

Other, please specify. (If checked, no further questions) ☐

_____

11. Will the requested drug be used in combination with Alhemo or Hympavzi? **Y** ☐ **N** ☐

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

13. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication? **Y** ☐ **N** ☐

14. What is the patient's body weight in kilograms (kg)?

Any weight; please specify. (If checked, go to 15) ☐

_____

Unknown (If checked, no further questions) ☐

15. What is the prescribed induction dose in milligrams (mg)?

Any dose; please specify. (If checked, go to 16) ☐

_____

Unknown (If checked, no further questions) ☐

16. Does the prescribed induction dose exceed 3 mg/kg subcutaneously once weekly for the first 4 weeks? **Y** ☐ **N** ☐

17. What is the patient's body weight in kilograms (kg)?

Any weight; please specify. (If checked, go to 18) ☐

_____

Unknown (If checked, no further questions) ☐

18. What is the prescribed maintenance dose in milligrams (mg)?

Any dose; please specify. (If checked, go to 19) ☐

_____

Unknown (If checked, no further questions) ☐

19. What is the prescribed frequency for the maintenance dose?

Once every week (If checked, go to 20) ☐

Once every two weeks (If checked, go to 21) ☐

Once every four weeks (If checked, go to 22) ☐

Other, please specify. (If checked, no further questions) ☐

_____

20. Does the prescribed maintenance dose exceed 1.5 mg/kg? **Y** ☐ **N** ☐

21. Does the prescribed maintenance dose exceed 3 mg/kg? **Y** ☐ **N** ☐

22. Does the prescribed maintenance dose exceed 6 mg/kg? **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.

_____

Prescriber (Or Authorized) Signature and Date

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