Hemo - Stimate

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: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the patient's diagnosis?
   - ❑ von Willebrand disease (VWD)
   - ❑ Hemophilia A
   - ❑ Qualitative platelet disorder
   - ❑ Acquired hemophilia A
   - ❑ Acquired von Willebrand syndrome (AVWS)
   - ❑ Other _____

2. Is the request for continuation of therapy? *If Yes, skip to #7* ❑ Yes ❑ No

3. If the patient's diagnosis is indicated below, *skip to the indicated question, or no further questions.*
   - ❑ von Willebrand disease (VWD), *continue to #4*
   - ❑ Hemophilia A, *skip to #6*
   - ❑ Qualitative platelet disorder, *no further questions.*
   - ❑ Acquired hemophilia A, *no further questions.*
   - ❑ Acquired von Willebrand syndrome (AVWS), *no further questions.*

4. What type of von Willebrand disease does the patient have?
   - ❑ Type 1
   - ❑ Type 2A, *no further questions.*
   - ❑ Type 2B
   - ❑ Type 2M, *no further questions.*
   - ❑ Type 2N, *no further questions.*
   - ❑ Type 3
   - ❑ Other _____

5. Does the patient have mild or moderate disease? ❑ Yes ❑ No *No further questions.*

6. What is the patient's baseline factor VIII activity level? _____% N*o further questions.*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

7. If the patient's diagnosis is indicated below, *skip to the indicated question.*
   - ❑ von Willebrand disease (VWD), *skip to #9*
   - ❑ Hemophilia A, *continue to #8*
   - ❑ Qualitative platelet disorder, *continue to #8*
   - ❑ Acquired hemophilia A, *continue to #8*
   - ❑ Acquired von Willebrand syndrome (AVWS), *continue to #8*

8. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
   ❑ Yes ❑ No *No further questions.*

9. What type of von Willebrand disease does the patient have?
   ❑ Type 1 ❑ Type 2A, *skip to #11*
   ❑ Type 2M, *skip to #11* ❑ Type 2N, *skip to #11*

10. Does the patient have mild or moderate disease? ❑ Yes ❑ No

11. How long has the patient received therapy with the requested drug? _____ months.
    If greater than or equal to 12 months, skip to #13

12. Has the patient been shown to be responsive to an initial trial of the requested drug?
    ❑ Yes ❑ No *No further questions.*

13. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
    ❑ 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)**

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