



Alphanate, Humate-P, Koate-DVI, Wilate 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.

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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

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Hemo - Alphanate, Humate-P, Koate-DVI, Wilate SGM - 04/2021.

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

Criteria Questions:

1. What drug is being prescribed? Alphanate Humate-P Koate-DVI Wilate Other _____
2. What is the diagnosis?
 Hemophilia A
 von Willebrand disease (VWD)
 Acquired hemophilia A
 Acquired von Willebrand syndrome (AVWS)
 Other _____
3. What is the ICD-10 code? _____
4. Is the requested medication prescribed by or in consultation with a hematologist? Yes No
5. Is the request for continuation of therapy? Yes No *If No, skip to diagnosis section*
6. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? Yes No
No further questions

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hemophilia A

7. What is the patient's baseline factor VIII assay level (% activity)? _____ % *If 5% or less, no further questions*
8. Has the patient had an insufficient response to desmopressin? *If Yes, no further questions* Yes No
9. Is there a clinical reason for not trying desmopressin first? Yes No
If Yes, indicate clinical reason: _____

Section B: von Willebrand Disease

10. What type of von Willebrand disease does the patient have? *If Type 2B or 3, no further questions.*
 Type 1 Type 2A Type 2B Type 2M Type 2N Type 3 Other _____
11. Has the patient had an insufficient response to desmopressin? *If Yes, no further questions* Yes No
12. Is there a clinical reason for not trying desmopressin first? Yes No
If Yes, indicate clinical reason: _____

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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