CVS caremark™ {{PANUMCODE}}

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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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Tardive dyskinesia
   - ❑ Tourette's syndrome
   - ❑ Chorea associated with Huntington's disease
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
4. Is the patient currently receiving the requested drug through samples (including starter pack obtained from healthcare professional) or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to diagnosis section. ❑ Yes ❑ No ❑ Unknown
5. *If diagnosis is tardive dyskinesia,* have the patient's tardive dyskinesia symptoms improved as indicated by a decrease from baseline in the score of the Abnormal Involuntary Movement Scale (AIMS) for items 1 to 7?
   ACTION REQUIRED: If Yes, attach current AIMS score. ❑ Yes ❑ No *No further questions*
6. *If diagnosis is chorea associated with Huntington's disease or Tourette's syndrome,* has the patient experienced stabilization or improvement in their condition since starting treatment with the requested drug?
   ❑ Yes ❑ No *No further questions*

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

Section A: Tardive Dyskinesia

7. Has the baseline score for items 1 to 7 of the Abnormal Involuntary Movement Scale (AIMS) been submitted?
   ACTION REQUIRED: If Yes, attach baseline AIMS score. ❑ Yes ❑ No

Section B: Chorea Associated with Huntington's Disease

8. Does the patient demonstrate characteristic motor examination features? ❑ Yes ❑ No

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

9. Is the diagnosis supported by laboratory results demonstrating an expanded *HTT* CAG repeat sequence of at least 36? *If Yes, no further questions.* ❑ Yes ❑ No

10. Does the patient have a positive family history for Huntington's disease? ❑ 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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