Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Cystadane

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?
   ❑ Homocystinuria ❑ Other _____
2. What is the ICD-10 code? _____
3. Will plasma methionine concentrations be monitored and kept below 1,000 micromol/L through dietary modification, and if necessary, a reduction in Cystadane dose? ❑ Yes ❑ No
4. Is the patient currently receiving Cystadane? ❑ Yes ❑ No *If No, skip to #9*
5. Is the total homocysteine level undetectable or present only in small amounts? *If Yes, skip to #8* ❑ Yes ❑ No
6. Is there a substantial decrease in homocysteine level? ❑ Yes ❑ No
7. Will the dose be increased until maximum tolerability or plasma total homocysteine level is undetectable or present in only small amounts? ❑ Yes ❑ No
8. Does the patient have cystathionine beta-synthase (CBS) deficiency? ❑ Yes ❑ No *No further questions*
9. Will Cystadane be used to decrease elevated homocysteine blood levels? ❑ Yes ❑ No
10. Does the patient have one of the following types of homocystinuria?
    ❑ Cystathionine beta-synthase (CBS) deficiency
    ❑ 5, 10- methylenetetrahydrofolate reductase (MTHFR) deficiency
    ❑ Cobalamin cofactor metabolism (cbl) defect
    ❑ Other _____
11. Was the diagnosis confirmed by enzyme analysis or genetic testing? ***ACTION REQUIRED: If yes, attach supporting chart note(s) or test results.*** ❑ 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