



Givlaari

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

Site of Service Questions:

- A. Where will this drug be administered?
- | | |
|---|---|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Clinical Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital | <input type="checkbox"/> On-campus Outpatient Hospital |
| <input type="checkbox"/> Physician office, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Clinical Questions</i> |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes - This is a continuation of an existing treatment.
- No - This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*

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. Givlaari SOC SGM – 02/2023.

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- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: Attach supporting clinical documentation.***
 Yes, skip to Clinical Criteria Questions No
- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: Attach supporting clinical documentation.*** Yes, skip to Clinical Criteria Questions No
- E. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: Attach supporting clinical documentation.*** Yes No

Criteria Questions:

1. What is the ICD-10 code? _____
1. What is the diagnosis?
 Acute hepatic porphyria
 Other _____
2. Is the patient currently receiving treatment with the requested medication? Yes *If Yes, skip to #8* No
3. Is the patient actively symptomatic? Yes No Unknown
4. Has the patient been tested for porphobilinogen (PBG) in the urine confirmed by a PBG quantitative, random urine test? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
 Yes No, skip to #6 Unknown, skip to #6.
5. Is the porphobilinogen level above lab reference range? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s). If Yes, no further questions*** Yes No
6. Has the patient been tested for a plasma or fecal porphyrin level? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** Yes No Unknown
7. Is the plasma or fecal porphyrin level above lab reference range? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** Yes No *No further questions.*
8. Is the patient receiving benefit from therapy (e.g., reduction in porphyria attacks that required hospitalizations, urgent healthcare visit, or intravenous hemin administration)? 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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