



## 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*
- 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

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

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- 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 diagnosis?
  - Acute hepatic porphyria
  - Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is the patient currently receiving treatment with the requested medication?  Yes  No *If No, skip to #5*
4. 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 *No further questions*
5. Is the patient actively symptomatic?  Yes  No  Unknown
6. 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 #8  Unknown, skip to #8
7. Is the porphobilinogen level above lab reference range? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s).** *If Yes, no further questions*  Yes  No
8. Has the patient been tested for a plasma or fecal porphyrin level? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s).**  Yes  No  Unknown
9. Is the plasma or fecal porphyrin level above lab reference range? **ACTION REQUIRED: If 'Yes', attach supporting chart note(s).**  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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