Hemgenix

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.

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: _____ **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*

Criteria Questions:

What is the ICD-10 code: _____

1. What is the diagnosis?

❒ Hemophilia B (congenital Factor IX deficiency), *Continue to #2*

❒ Other, *Continue to #2*

2. Is the patient 18 years of age or older?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

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

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

3. Will the requested medication be prescribed by or in consultation with a hematologist?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. Does the patient have a negative Factor IX inhibitor test result within the past 30 days? ***ACTION REQUIRED****: If 'Yes', please attach lab results showing absence of Factor IX inhibitors*

❒ Yes, *Continue to #6*

❒ No, *Continue to #5*

5. Does the patient have a positive Factor IX inhibitor test result within the past 30 days, followed by a negative test result within two weeks of the initial positive result? ***ACTION REQUIRED****: If 'Yes', please attach lab results showing absence of Factor IX inhibitors*

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. Has the patient previously received gene therapy treatment?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Does the patient have severe or moderately severe Factor IX deficiency (≤2% of normal circulating Factor IX)? ***ACTION REQUIRED****: If 'Yes', please attach chart notes, medical records or lab tests confirming severe to moderately severe Factor IX deficiency (≤2% of normal circulating Factor IX)*

❒ Yes, *Continue to #8*

❒ No, *Continue to #8*

8. Is the patient currently using Factor IX prophylactic therapy? ***ACTION REQUIRED****: If 'Yes', please attach chart notes or medical records supporting current use of Factor IX prophylactic therapy*

❒ Yes, *No Further Questions*

❒ No, *Continue to #9*

9. Does the patient have a current or a history of a life-threatening hemorrhage? ***ACTION REQUIRED****: If 'Yes', please attach chart notes or medical records supporting current or past life-threatening hemorrhage*

❒ Yes, *No Further Questions*

❒ No, *Continue to #10*

10.Does the patient have a history of repeated, serious spontaneous bleeding episodes? ***ACTION REQUIRED***: If 'Yes', please attach chart notes or medical records supporting history of repeated, serious spontaneous bleeding episodes

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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