Hemlibra

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.

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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:** _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the diagnosis?
   ❑ Hemophilia A (congential factor VIII deficiency)
   ❑ Acquired hemophilia A
   ❑ Other _____
2. Is the requested medication prescribed by or in consultation with a hematologist? ❑ Yes ❑ No
3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*
4. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No
5. Will the patient use the requested medication for prophylactic use in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.)? ❑ Yes ❑ No *If No, skip to #16*
6. Is the requested medication being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑ Yes ❑ No
7. What is the patient's baseline factor VIII assay level?
   ❑ Less than 1% to 5% (moderate or severe disease), *skip to #11*
   ❑ Greater than 5% (mild disease)
8. Has the patient had an insufficient response to desmopressin? *If Yes, skip to #11* ❑ Yes ❑ No
9. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No

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

10. What is the reason? Please indicate the clinical reason for not trying desmopressin first.
    - ❑ Age less than 2 years
    - ❑ Pregnancy
    - ❑ Fluid/electrolyte imbalance
    - ❑ High risk for cardiovascular or cerebrovascular disease (especially the elderly)
    - ❑ Predisposition to thrombus formation
    - ❑ Trauma requiring surgery
    - ❑ Life-threatening bleed
    - ❑ Contraindication or intolerance to desmopressin
    - ❑ Stimate Nasal Spray is unavailable due to backorder/shortage issues (where applicable)
    - ❑ Other: _____

11. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication? ❑ Yes ❑ No

12. What is the patient's body weight in kilograms? _____ kg ❑ Unknown

13. What is the prescribed induction dose in milligrams (mg)? _____ mg ❑ Unknown

14. Is the prescribed frequency more frequent than once weekly for the first 4 weeks? ❑ Yes ❑ No

15. Does the prescribed induction dose exceed 3 mg/kg subcutaneously for the first 4 weeks?
    ❑ Yes ❑ No *If No, skip to #17*

16. What is the patient's body weight in kilograms? _____ kg ❑ Unknown

17. What is the prescribed induction dose in milligrams (mg)? _____ mg ❑ Unknown

18. What is the prescribed frequency for the maintenance dose?
    - ❑ Once every week
    - ❑ Once every two weeks, *skip to #20*
    - ❑ Once every four weeks, *skip to #21*
    - ❑ Other: _____

19. Does the prescribed maintenance dose exceed 1.5 mg/kg? *Please calculate dose from responses to questions #16 and #17.* ❑ Yes ❑ No *No further questions*.

20. Does the prescribed maintenance dose exceed 3 mg/kg? *Please calculate dose from responses to questions #16 and #17.* ❑ Yes ❑ No *No further questions*.

21. Does the prescribed maintenance dose exceed 6 mg/kg? *Please calculate dose from responses to questions #16 and #17.* ❑ Yes ❑ 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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