Factor VIII Agents (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Exception Criteria Questions:

A. Is the requested product Helixate FS? ❑ Yes ❑ No, *skip to Clinical Criteria Questions*

B. *The preferred product for your patient's health plan is Kogenate FS. (Please note: Kogenate FS and Helixate FS are the exact same products with different labels and brand names, which are made by the same manufacturer.)* Can the patient's treatment be switched to Kogenate FS?.
❑ Yes, *skip to Clinical Criteria Questions and mark #1 as Kogenate FS* ❑ No

C. Given that Kogenate FS and Helixate FS are the same products, is there a clinical reason that the patient must use Helixate FS over Kogenate FS? ❑ Yes ❑ No

D. Is this clinical reason documented in the patient's chart? ***ACTION REQUIRED:*** **Documentation is required for approval. Provide SPECIFIC AND DETAILED chart documentation including description, date/time, and severity of the clinical reason, dosage and duration of Preferred Product trial, required intervention (if any), and relevant rests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.** ❑ Yes ❑ No

Criteria Questions:

1. What drug is being prescribed?
   ❑ Advate ❑ Hemofil M ❑ Kogenate FS ❑ Monoclate-P ❑ Novoeight
   ❑ Nuwiq ❑ Recombinate ❑ Xyntha ❑ Other _____

2. What is the diagnosis?
   ❑ Hemophilia A
   ❑ Acquired hemophilia A
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to diagnosis section*

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to diagnosis section and complete this form in its entirety.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Hemophilia A

7. What is the patient's baseline factor VIII assay level (% activity)? _____ % *If 5% or less, no further questions.*

8. Has the patient had an insufficient response to desmopressin? *If Yes, no further questions* ❑ Yes ❑ No

9. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
   ***If Yes, indicate the reason*: _____**

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)**