CareFirst. Family of health care plans

CVS caremark™

Kalbitor (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.

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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:** ___________________

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*

Criteria Questions:

1. What is the diagnosis?
   ❑ Hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing
   ❑ HAE with normal C1 inhibitor confirmed by laboratory testing
   ❑ Other ____

2. What is the ICD-10 code? _____________

3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to #6*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***Action Required**: If Yes, 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.)*

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

6. Which of the following conditions does the patient have?
   ❑ F12 gene mutation as confirmed by genetic testing
   ❑ Family history of angioedema AND angioedema refractory to a trial of antihistamine (e.g. cetirizine) greater than or equal to one month
   ❑ Other ___________________________________

7. Is Kalbitor being used for the treatment of acute HAE attacks? ❑ Yes ❑ No

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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)**