CareFirst Family of health care plans

CVS caremark™

Krystexxa

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:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: ________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*__________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Krystexxa SGM – 8/2018.

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). ® Registered trademark of the Blue Cross and Blue Shield Association

Criteria Questions:

1. What is the patient's diagnosis? ❑ Chronic gout ❑ Other ___________________________________
2. What is the ICD-10 code? __________________
3. Will Krystexxa be used concomitantly with oral urate-lowering therapies (e.g., allopurinol, Uloric [febuxostat])?
   ❑ Yes ❑ No
4. Is this a request for continuation of therapy with Krystexxa after at least 3 months of therapy (i.e., six doses)?
   ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving Krystexxa through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #7 ❑ Yes ❑ No ❑ Unknown
6. Has the patient had 2 consecutive uric acid levels above 6 mg/dL? ❑ Yes ❑ No *No further questions*
7. Has patient had an inadequate response to **at least a 3-month trial** of ANY of the following medications at the medically appropriate maximum dose? ***Indicate ALL that apply or mark " None of the above."***
   ❑ Yes - Allopurinol ❑ Yes - Probenecid alone or in combination with allopurinol or febuxostat
   ❑ Yes - Uloric (febuxostat) ❑ None of the above
8. Does the patient have a clinical reason for not completing at least a 3 month trial of allopurinol at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interation, or severe renal dysfunction)? ❑ Yes ❑ No
9. Does the patient have a clinical reason for not completing at least a 3 month trial of Uloric (febuxostat) at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, or significant drug interaction)? ❑ Yes ❑ No
10. Does the patient have a clinical reason for not completing at least a 3 month trial of probenecid at the medically appropriate maximum dose (e.g., severe allergic reaction, intolerance, toxicity, significant drug interaction, known blood dyscrasias, uric acid kidney stones, or renal insufficiency)? ❑ 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)**