CVS caremark™ **{{PANUMCODE}}**

Litfulo

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.

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Severe alopecia areata
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Does the prescribed dose exceed 50 mg? ❑ Yes ❑ No
4. Does the prescribed frequency exceed one dose once daily? ❑ Yes ❑ No
5. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Dupixent, Humira), targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla) or potent immunosuppressant such as azathioprine or cyclosporine?
   ❑ Yes ❑ No
6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #10* ❑ Yes ❑ No
7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No
8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB
   ❑ Negative for TB, *skip to #10*
   ❑ Unknown
9. Which of the following applies to the patient?
   ❑ Patient has latent TB and treatment for latent TB has been initiated
   ❑ Patient has latent TB and treatment for latent TB has been completed
   ❑ Patient has latent TB and treatment for latent TB has not been initiated
   ❑ Patient has active TB
10. Is the requested drug being prescribed by or in consultation with a dermatologist? ❑ Yes ❑ No

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

11. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #15*
12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #15* ❑ Yes ❑ Unknown ❑ No
13. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug? ❑ Yes ❑ No
14. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage, 80% total scalp hair coverage [SALT score of 20 or less])? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation and no further questions.*** ❑ Yes ❑ No
15. Does the patient have more than 50% scalp hair loss (e.g., Severity of Alopecia Tool [SALT] score of 50 or higher)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of SALT score.*** ❑ Yes ❑ No
16. Have other forms of alopecia been ruled out (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss, tinea capitis)? ❑ 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)**

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