CareFirst
Family of health care plans

CVS caremark™

Prolia (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.

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?
   - ❑ Postmenopausal osteoporosis
   - ❑ Osteoporosis in a male patient
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ 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: ***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.*

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

Section A: Postmenopausal Osteoporosis and Osteoporosis in a Male Patient

6. *If diagnosis is osteoporosis in a male patient,* does the patient have a history of an osteoporotic vertebral or hip fracture? *If Yes, no further questions* ❑ Yes ❑ No, *skip to #12*

7. Does the patient have a history of fragility fractures? *If Yes, no further questions* ❑ Yes ❑ No

8. Does the patient have any indicators of higher fracture risk? ❑ Yes ❑ No
   If Yes, indicate the higher fracture risk inidicator: __________________________________

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9. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., zoledronic acid [Reclast], teriparatide [Forteo])? ❑ Yes ❑ No

10. Has the patient had at least a 1-year trial of an oral bisphosphonate?
❑ Yes, ***indicate:*** ____ ❑ No

11. *If patient has not had at least a 1-year trial of an oral bisphosphonate,* is there a clinical reason to avoid treatment with an oral bisphosphonate? ***Indicate below or mark "None of the above"***
❑ Esophageal abnormality that delays emptying such as stricture or achalasia
❑ Active upper gastrointestinal problem (eg, dysphagia, erosive esophagitis)
❑ Inability to stand or sit upright for 30 to 60 minutes
❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
❑ Renal insufficiency (creatinine clearance less than 30 ml/min)
❑ History of intolerance to an oral bisphosphonate
❑ Other ____
❑ None of the above
❑ Not applicable

12. What is the patient's pretreatment T-score? ____________ ❑ Unknown
If less than or equal to -2.5 (ex. -3, -4), no further questions.

13. What is the patient's pretreatment FRAX score for any major fracture*? ____________ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

14. What is the patient's pre-treatment FRAX score for hip fracture*? ____________ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

Section B: Breast and Prostate Cancer

15 *If diagnosis is breast cancer,* is the patient receiving adjuvant aromatase inhibitor therapy for breast cancer?
❑ Yes ❑ No ❑ Not applicable

16. *If diagnosis is prostate cancer,* is the patient receiving androgen-deprivation therapy for prostate cancer?
❑ Yes ❑ No ❑ Not applicable

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)**