Ravicti

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.

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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:** ___________________
Request Initiated For: _____________________

1. What is the patient's diagnosis? ❑ Urea cycle disorder ❑ Other ______________________________________
2. What is the ICD-10 code? ______________
3. Is the product being requested for the treatment of urea cycle disorders? ❑ Yes ❑ No *If No, skip to #8*
4. The preferred product for your patient's health plan is sodium phenylbutyrate. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
5. Does the patient have documented uncontrolled congestive heart failure, uncontrolled hypertension, or severe renal impairment (i.e., creatinine clearance less than 30 mL/min) and is on a documented sodium-restricted diet? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #8.*** ❑ Yes ❑ No
6. Does the patient have a documented inability to ingest a sufficient amount of the preferred product as prescribed due to an aversion to the taste or smell? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #8.*** ❑ Yes ❑ No
7. Does the patient have a documented inability to tolerate the necessary pill burden with the preferred product? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
8. Will Ravicti be used for chronic management of a urea cycle disorder? ❑ Yes ❑ No
9. Is this request for continuation of treatment with Ravicti? *If Yes, skip to #12* ❑ Yes ❑ No
10. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
11. Does the patient have elevated plasma ammonia levels at baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels.*** ❑ Yes ❑ No *No further questions.*

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

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12. Is the patient experiencing benefit from therapy with the requested drug as evidenced by a reduction in plasma ammonia levels from baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for plasma ammonia levels.*** ❑ 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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CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081

Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com