CareFirst

The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

RiaSTAP

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 drug is being prescribed? ❑ RiaSTAP ❑ Other _______________________________
2. What is the patient's diagnosis?
   ❑ Congenital fibrinogen deficiency
   ❑ Other ____
3. What is the ICD code? _______________
4. Which type of congenital fibrinogen deficiency does the patient have?
   ❑ Afibrinogenemia
   ❑ Hypofibrinogenemia
   ❑ Dysfibrinogenemia
   ❑ Hypodysfibrinogenemia *If hypodysfibrinogenemia, skip to #7.*
5. Was the diagnosis confirmed by low or absent fibrinogen levels? ❑ Yes ❑ No
   ***ACTION REQUIRED:* Attach laboratory documentation.**
6. Is laboratory report of fibrinogen level attached to the request? ❑ Yes ❑ No
7. *If hypodysfibrinogenemia,* what is the patients functional (clotting) fibrinogen level?
   ***ACTION REQUIRED:* Attach laboratory documentation.** ____________ mg/dL ❑ Not applicable
8. Is laboratory report of functional (clotting) fibrinogen level attached to the request? ❑ Yes ❑ No
9. Is RiaSTAP requested for the treatment of an **acute** bleeding episode? *If Yes, no further questions* ❑ Yes ❑ No
10. Is RiaSTAP requested for the management of surgical bleeding (including prophylaxis to **prevent** a bleeding episode)? ❑ Yes ❑ No

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

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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)**