



Hemo - Stimate

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: _____ NPI#: _____
Specialty: _____ Physician Office Fax: _____
Physician Office Telephone: _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: Yes No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the patient's diagnosis?
 von Willebrand disease (VWD)
 Hemophilia A
 Qualitative platelet disorder
 Acquired hemophilia A
 Acquired von Willebrand syndrome (AVWS)
 Other _____
2. Is the request for continuation of therapy? *If Yes, skip to #7* Yes No
3. If the patient's diagnosis is indicated below, *skip to the indicated question, or no further questions.*
 von Willebrand disease (VWD), *continue to #4*
 Hemophilia A, *skip to #6*
 Qualitative platelet disorder, *no further questions.*
 Acquired hemophilia A, *no further questions.*
 Acquired von Willebrand syndrome (AVWS), *no further questions.*
4. What type of von Willebrand disease does the patient have?
 Type 1 Type 2A, *no further questions.*
 Type 2B Type 2M, *no further questions.*
 Type 2N, *no further questions.* Type 3
 Other _____
5. Does the patient have mild or moderate disease? Yes No *No further questions.*
6. What is the patient's baseline factor VIII activity level? _____% *No further questions.*

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

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. Hemo - Stimate SGM - 4/2023.

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7. If the patient's diagnosis is indicated below, *skip to the indicated question.*
- von Willebrand disease (VWD), *skip to #9*
 - Hemophilia A, *continue to #8*
 - Qualitative platelet disorder, *continue to #8*
 - Acquired hemophilia A, *continue to #8*
 - Acquired von Willebrand syndrome (AVWS), *continue to #8*
8. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
- Yes No *No further questions.*
9. What type of von Willebrand disease does the patient have?
- Type 1 Type 2A, *skip to #11*
 - Type 2M, *skip to #11* Type 2N, *skip to #11*
10. Does the patient have mild or moderate disease? Yes No
11. How long has the patient received therapy with the requested drug? _____ months.
If greater than or equal to 12 months, skip to #13
12. Has the patient been shown to be responsive to an initial trial of the requested drug?
- Yes No *No further questions.*
13. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
- 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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