Tzield

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Tzield SGM 5678-A - 07.2023.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
   ❑ Stage 2 Type 1 Diabetes
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this request to delay the onset of stage 3 type 1 diabetes? ❑ Yes ❑ No
4. *If the patient is 8 years of age or older,* will the requested drug be prescribed by or in consultation with an endocrinologist? ❑ Yes ❑ No ❑ N/A - patient is less than 8 years of age
5. Does the patient have 2 or more of the following pancreatic islet cell autoantibodies detected in two samples obtained within the past 6 months? ***ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes with 2 or more of the pancreatic islet cell autoantibodies detected in two samples obtained within the past 6 months).*** ❑ Yes ❑ No ❑ Unknown
   a) Glutamic acid decarboxylase 65 (GAD) autoantibodies
   b) Insulin autoantibody (IAA)
   c) Insulinoma-associated antigen 2 autoantibody (IA-2A)
   d) Zinc transporter 8 autoantibody (ZnT8A)
   e) Islet cell autoantibody (ICA)
6. Does the patient have an abnormal oral glucose tolerance test (OGTT) confirming dysglycemia within the past 2 months? ***ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes with an abnormal oral glucose tolerance test (OGTT) confirming dysglycemia within the past 2 months).***
   ❑ Yes ❑ No ❑ Unknown
7. Does the patient have a fasting blood glucose level of 110 to 125 mg/dL (6.1 to 6.9 mmol/L)?
   ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes with a fasting blood glucose level of 110 to 125 mg/dL (6.1 to 6.9 mmol/L). *If Yes, skip to #10* ❑ Yes ❑ No
8. Does the patient have a 2-hour postprandial plasma glucose level of at least 140 mg/dL (7.8 mmol/L) and less than 200 mg/dL (11.1 mmol/L)? ***ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes with a 2-hour postprandial plasma glucose level of at least 140 mg/dL (7.8 mmol/L) and less than 200 mg/dL (11.1 mmol/L).*** *If Yes, skip to #10* ❑ Yes ❑ No
9. Does the patient have an intervening postprandial glucose level at 30, 60, or 90 minutes of greater than 200 mg per deciliter (11.1 mmol/L) on two or more occasions? ***ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes with an intervening postprandial glucose level at 30, 60, or 90 minutes of greater than 200 mg per deciliter (11.1 mmol/L) on two or more occasions).*** ❑ Yes ❑ No
10. Does the patient have symptoms associated with type 1 diabetes (e.g., increased urination, excessive thirst, weight loss)? ❑ Yes ❑ No
11. Will the patient exceed a one-time 14-day treatment course consisting of the following dosing schedule?
    ❑ Yes ❑ No
    a) Day 1: 65 mcg/m^2
    b) Day 2: 125 mcg/m^2
    c) Day 3: 250 mcg/m^2
    d) Day 4: 500 mcg/m^2
    e) Days 5 through 14: 1,030 mcg/m^2

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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720