CVS caremark™ {{PANUMCODE}}

Zokinvy

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.

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   - ❑ Hutchinson-Gilford progeria syndrome
   - ❑ Processing deficient progeroid laminopathy with progerin-like protein accumulation
   - ❑ Processing deficient progeroid laminopathy without progerin-like protein accumulation
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body surface area (BSA)? _____ meters squared
4. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
5. Has the patient experienced a benefit from therapy? ❑ Yes ❑ No *No further questions.*

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

Section A: Hutchinson-Gilford Progeria Syndrome

6. Has the diagnosis of Hutchinson-Gilford Progeria Syndrome been confirmed with genetic testing indicating the patient has a *LMNA* mutation? ***ACTION REQUIRED: If Yes, attach genetic testing results.***
   - ❑ Yes
   - ❑ No
   - ❑ Unknown

Section B: Processing Deficient Progeroid Laminopathy with Progerin-Like Protein Accumulation

7. Has the diagnosis of Processing Deficient Progeroid Laminopathy with Progerin-Like Protein Accumulation been confirmed with genetic testing indicating the patient has a heterozygous *LMNA* mutation?
   ACTION REQUIRED: If Yes, attach genetic testing results.
   - ❑ Yes
   - ❑ No
   - ❑ Unknown

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

Section C: Processing Deficient Progeroid Laminopathy without Progerin-Like Protein Accumulation

8. Has the diagnosis of Processing Deficient Progeroid Laminopathy without Progerin-Like Protein Accumulation been confirmed with genetic testing indicating the patient has a homozygous or compound heterozygous *ZMPSTE24* mutation? ***ACTION REQUIRED: If Yes, attach genetic testing results.***
   - ❑ Yes
   - ❑ No
   - ❑ Unknown

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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