Hemlibra

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

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 - Hemlibra SGM - 06/2021.

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?
   ❑ Hemophilia A (congential factor VIII deficiency)
   ❑ Acquired hemophilia A
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight in kilograms?_____kg
4. What is the prescribed dose?
   ❑ **Loading dose (if applicable) -** Quantity and Frequency: _____
   ❑ **Maintenance dose -** Quantity and Frequency: _____
5. Is the requested medication prescribed by or in consultation with a hematologist? ❑ Yes ❑ No
6. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #9*
7. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No
8. Will the patient use the requested medication for prophylactic use in combination with factor VIII products (e.g., Advate, Adynovate, Eloctate, etc.)? ❑ Yes ❑ No *No further questions*
9. Is the requested mediction being requested for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ❑ Yes ❑ No
10. What is the patient's baseline factor VIII assay level?_____% activity
    If less than 1% - 5%, skip to #13
11. Has the patient had an insufficient response to desmopressin? *If Yes, skip to #13* ❑ Yes ❑ No
12. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
    If Yes, indicate clinical reason _____
13. Will prophylactic use of factor VIII products (e.g., Advate, Adynovate, Eloctate) be discontinued after the first week of starting therapy with the requested medication? ❑ 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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