Cayston

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: ______________________________ **Date**: __________________________________
Patient's ID: _________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: ___________________________________ **NPI#:** __________________________________
Physician Office Telephone: ___________________ **Physician Office Fax:** ____________________
Request Initiated For: _________________________

1. What is the patient's diagnosis?
   ❑ Cystic fibrosis
   ❑ Other ____
2. What is the ICD-10 code? _______________
3. Is the product being requested for the treatment of respiratory symptoms in cystic fibrosis patients with *Pseudomonas aeruginosa*? ❑ Yes ❑ No *If No, skip to #11*
4. The preferred product for your patient's health plan is generic tobramycin inhalation solution. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes ❑ No - Continue request for non-preferred product
5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*
6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #11*
7. Will the patient be receiving the requested product in combination with the preferred product?
   If Yes, skip to #11 ❑ Yes ❑ No
8. Does the patient have a documented inadequate response to treatment with the preferred product?
   ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #11. ❑ Yes ❑ No
9. Does the patient have a documented intolerable adverse event to the preferred product?
   ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #11. ❑ Yes ❑ No
10. Does the patient have a documented contraindication to the preferred product?
    ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No
11. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #13*

12. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions.*

13. Does the patient have *Pseudomonas aeruginosa* present in airway cultures?
If Yes, no further questions. ❑ Yes ❑ No

14. Does the patient have a history of *Pseudomonas aeruginosa* infections or colonization in the airways?
❑ 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)**

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. Cayston SGM - 7/2023.

CVS Caremark Prior Authorization ● 1300 E. Campbell Road ● Richardson, TX 75081
Phone: 1-866-814-5506 ● Fax: 1-866-249-6155 ● www.caremark.com