Crysvita

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the member 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*

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Questions*
- ❑ Off-campus Outpatient Hospital
- ❑ Physician office, *skip to Clinical Questions*
- ❑ Home infusion, *skip to Clinical Questions*
- ❑ On-campus Outpatient Hospital
- ❑ Pharmacy, *skip to Clinical Questions*

B. Is the patient less than 21 years old or 65 years of age or older?
- ❑ Yes – less than 21 years old, *skip to Clinical Criteria Questions*
- ❑ Yes – age 65 years or older, *skip to Clinical Criteria Questions*
- ❑ No

C. Is this request to continue previously established treatment with the requested medication?
- ❑ Yes - This is a continuation of an existing treatment.
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*

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

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

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids or other pre- medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?
   ❑ X-linked hypophosphatemia
   ❑ FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis specific section*
4. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis specific section.* ❑ Yes ❑ No ❑ Unknown
5. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? (e.g., increase or normalization in serum phosphate, improvement in bone and joint pain, reduction in fractures, improvement in skeletal deformities). ***ACTION REQUIRED: If yes, please submit documentation (e.g., chart notes, lab test results)*** ❑ Yes ❑ No *No further questions.*

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

Section A: X-linked hypophosphatemia

6. Does the patient have a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing? ***ACTION REQUIRED: If Yes, please submit genetic test results.*** *If Yes, skip to #9* ❑ Yes ❑ No
7. Was a known PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation confirmed by genetic testing in a directly related family member with appropriate X-linked inheritance? ***ACTION REQUIRED: If Yes, please submit genetic test results.*** *If Yes, skip to #9* ❑ Yes ❑ No
8. Is the patient's serum fibroblast growth factor 23 (FGF23) above the upper limit of normal or abnormal for the assay? ***ACTION REQUIRED: If Yes, please submit laboratory test results.*** ❑ Yes ❑ No ❑ Unknown
9. Does the patient have radiographic evidence of rickets or other bone disease attributed to XLH? ***ACTION REQUIRED: If yes, please submit corresponding test results.*** ❑ Yes ❑ No

Section B: FGF23-related hypophosphatemia in tumor induced osteomalacia (TIO)

10. Is the patient's disease associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized? ❑ Yes ❑ No

11. Is the member's diagnosis confirmed by ALL of the following? ***ACTION REQUIRED: If yes, please submit corresponding laboratory documentation.*** ❑ Yes ❑ No
    - FGF23 level is above the upper limit of normal or abnormal for the assay
    - Fasting serum phosphorus levels are less than 2.5 mg/dL
    - Ratio of renal tubular maximum reabsorption rate of phosphate to glomerular filtration rate (TmP/GFR) is less than 2.5 mg/dL

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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