CareFirst Family of health care plans

CVS caremark™

Cuvitru

Prior Authorization Request

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

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 **1-866-814-5506.** 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:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the diagnosis?
   ❑ Primary immunodeficiency (eg, common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of immune globulin therapy? ❑ Yes ❑ No *If No, skip to #8*
4. Has the patient experienced a reduction in the frequency of bacterial infections since starting immune globulin therapy? ❑ Yes ❑ No
5. Does the prescriber measure trough IgG levels at least once per year?
   ❑ Yes ❑ No ❑ Not applicable for diagnosis
6. Is the most recent trough IgG level at or above the lower range of normal for age? ***ACTION REQUIRED: Attach a copy of the laboratory report with a recent IgG trough level***
   ❑ Yes, *no further questions* ❑ No ❑ Not applicable for diagnosis, *no further questions*

7. Will the prescriber re-evaluate the dose of immune globulin and consider a dose adjustment (when clinically appropriate)? ❑ Yes ❑ No ❑ Not applicable/not clinically appropriate *No further questions*

8. What is the specific immunodeficiency disorder?
❑ Severe combined immunodeficiency (SCID), ***specify:***
_____
❑ Congenital agammaglobulinemia (eg, X-linked or autosomal recessive agammaglobulinemia)
❑ Other non-SCID combined immunodeficiency disorder, ***specify:***
_____
❑ Common variable immunodeficiency (CVID)
❑ Hypogammaglobulinemia (unspecified) or other predominant antibody deficiency disorder
❑ Selective IgA deficiency
❑ Selective IgM deficiency
❑ IgG subclass deficiency
❑ Specific antibody deficiency
❑ Other immunodeficiency disorder/none of the above. ***Specify*:**
_____

9. ***ACTION REQUIRED:*** Please indicate and attach a copy of the following **pre-treatment** laboratory information (where applicable):

- IgG (total) level: _____ mg/dL
  a) Is IgG (total) level within the normal reference range? ❑ Yes ❑ No
  b) If No, is the IgG level greater than or equal to (≥) 2 SD below the mean for age? ❑ Yes ❑ No
- IgG subclass levels:
  a) IgG1 _____ mg/dL
  b) IgG2 _____ mg/dL
  c) IgG3 _____ mg/dL
  d) Other_____
  e) Are the IgG subclass levels within the normal reference range? ❑ Yes ❑ No
  f) If No, is the level(s) greater than or equal to (≥) 2 SD below the mean for age? ❑ Yes ❑ No
  g) Were IgG subclass levels measured on at least 2 different occasions? ❑ Yes ❑ No
- IgA level: _____ mg/dL
  a) Is the IgA level within the normal reference range? ❑ Yes ❑ No
- IgM level: _____ mg/dL
  a) Is the IgM level within the normal reference range? ❑ Yes ❑ No

10. *If diagnosis is severe combined immunodeficiency,* are maternal T cells present in the circulation? *If Yes, no further questions.* ❑ Yes ❑ No

11. *If diagnosis is severe combined immunodeficiency,* what is the patient's CD3 T cell count? _____ per microliter ***ACTION REQUIRED: Attach a copy of the laboratory report with lymphocyte subset enumeration by flow cytometry.*** *No further questions*

12. Has the patient demonstrated an impaired antibody response to vaccination with a pneumococcal polysaccharide vaccine? ***ACTION REQUIRED: If yes, please attach a copy of the laboratory report with post-vaccination titers.*** ❑ Yes ❑ No ❑ Not applicable

13. If applicable, was the diagnosis confirmed by molecular or genetic testing? ***ACTION REQUIRED: Please attach a copy of the laboratory report or other medical record that shows the results of molecular/genetic testing.***
❑ Yes ❑ No ❑ Not applicable to diagnosis

14. Have other causes of immune deficiency been excluded (eg, drugs, infectious disease, malignancy)?
❑ Yes ❑ No ❑ Not applicable to diagnosis

15 Does the patient have a history of recurrent bacterial infections (eg, pneumonia, otitis media, sinusitis, sepsis, gastrointestinal infections)? ❑ Yes ❑ No

16. Was the immune globulin therapy initiated in the hospital setting? ❑ 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)**