Empaveli

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.

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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. Empaveli SGM – 10/2021.

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

Clinical Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Paroxysmal nocturnal hemoglobinuria (PNH)
   ❑ Other ____
2. What is the ICD-10 code? _____________
3. Does the prescribed dose exceed 1,080 mg by subcutaneous infusion? ❑ Yes ❑ No
4. Is the prescribed frequency more frequent than one dose twice weekly? ❑ Yes ❑ No *If No, skip to #7*
5. Does the patient have a lactate dehydrogenase (LDH) level greater than two times the upper limit of normal (ULN)?
   ❑ Yes ❑ No
6. Is the prescribed frequency more frequent than one dose every three days? ❑ Yes ❑ No
7. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #10*
8. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
9. Did the patient demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels)? ***ACTION REQUIRED: If yes, please attach chart notes or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No *No further questions*
10. Was the diagnosis of PNH confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs)? ❑ Yes ❑ No
11. How was the diagnosis established?
    ❑ Quantification of PNH cells
    ❑ Quantification of GPI-anchored protein deficient poly-morphonuclear cells
    ❑ None of the above
12. *If patient's diagnosis is established by Quantification of PNH cells,* what was the percentage of PNH cells?
    ______________ %
13. *If patient's diagnosis is established by Quantification of GPI-anchored protein deficient poly-morphonuclear cells,* what was the percentage of GPI-anchored protein deficient poly-morphonuclear cells? __________ %
14. Was flow cytometry used to demonstrate the deficiency of GPI-anchored proteins? ***ACTION REQUIRED: If yes, please attach flow cytometry report.*** ❑ 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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