Factor IX, Factor IX Complex

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*

Exception Criteria Questions:

A. What drug is being prescribed?

❑ Alphanine SD, *Skip to Clinical Questions*
❑ Alprolix
❑ Benefix, *Skip to Clinical Questions*
❑ Rixibus, *Skip to Clinical Questions*
❑ Idelvion, *Skip to Clinical Questions*
❑ Ixinity, *Skip to Clinical Questions*
❑ Mononine, *Skip to Clinical Questions*
❑ Profilnine, *Skip to Clinical Questions*
❑ Rebinyn, *Skip to Clinical Questions*
❑ Other _____, *Skip to Clinical Questions*

B. Is the product being requested for the treatment of Hemophilia B?

❑ Yes ❑ No *If No, Skip to Clinical Questions*

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

 Hemo - Factor IX, IX Complex MR SGM – 05/2022.

C. *The preferred products for your patient's health plan are Idelvion and Rebinyn.*
Can the patient's treatment be switched to any of the preferred products?
❑ Yes – Idelvion, *Skip to Clinical Questions*
❑ Yes – Rebinyn, *Skip to Clinical Questions*
❑ No

D. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to Question F*

E. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No *If No, skip to Clinical Questions*

F. Is Alprolix being requested for routine prophylaxis to reduce the frequency of bleeding episodes?
❑ Yes *If Yes, skip to Question H* ❑ No

G. Does the patient have a documented inadequate response to treatment, intolerable adverse event, or contraindication to both of the preferred products (Idelvion and Rebynin)? ***ACTION REQUIRED*: If Yes, please attach supporting chart notes(s) and skip to Clinical Questions** ❑ Yes ❑ No

H. Does the patient have a documented inadequate treatment response, intolerable adverse event, or contraindication to the preferred product (Idelvion)? ***ACTION REQUIRED*: If Yes, please attach supporting chart notes(s).**
❑ Yes ❑ No

Criteria Questions:

1. What drug is being prescribed?
❑ Alprolix ❑ Benefix ❑ Ixinity ❑ Idelvion ❑ Rixubis ❑ Alphanine SD ❑ Mononine ❑ Rebinyn
❑ Profilnine ❑ Other _____
2. What is the diagnosis?
❑ Hemophilia B
❑ Bleeding due to low levels of liver-dependent coagulation factors
❑ Factor II deficiency
❑ Other _____
3. What is the ICD-10 code? _____
4. Is the requested medication prescribed by or in consultation with a hematologist? ❑ Yes ❑ No
5. Is the request for continuation of therapy? ❑ Yes ❑ No, *If No, no further questions*
6. Is the patient experiencing benefit from therapy (e.g., reduced frequency or severity of bleeds)? ❑ 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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