GamaSTAN S/D (for Maryland only)

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.

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*

Criteria Questions:

1. What is the intended use for GamaSTAN S/D?
   - ❑ Prophylaxis of hepatitis A
   - ❑ Prophylaxis of varicella (chickenpox)
   - ❑ Prophylaxis of measles (rubeola)
   - ❑ Prophylaxis of rubella
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

Complete the following section based on the intended use of therapy.

Section A: Prophylaxis of Hepatitis A

6. Was the patient exposed to hepatitis A virus within the past 2 weeks? *If Yes, no further questions* ❑ Yes ❑ No
7. Is the patient at high risk for exposure to hepatitis A virus? ❑ Yes ❑ No

Section B: Prophylaxis of Measles (rubeola)

8. Was the patient exposed to measles within the past 6 days? ❑ Yes ❑ No

Section C: Prophylaxis of Varicella (chickenpox)

9. Was the patient exposed to varicella within the past 10 days? ❑ Yes ❑ No

10. Is the patient at high risk for severe varicella (eg, immunocompromised, newborn/infant, pregnant woman)?
    ❑ Yes ❑ No

11. Is varicella zoster immune globulin (eg, Varizig) currently **not** available? ❑ Yes ❑ No

Section D: Prophylaxis of Rubella

12. Was the patient recently exposed to rubella? ❑ Yes ❑ No

13. Is the patient a pregnant woman? ❑ 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)**