CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

HyQvia

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. Which drug is being prescribed? ❑ HyQvia ❑ Other _________________
2. What is the patient's diagnosis?
   ❑ Primary immunodeficiency (eg, common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)
   ❑ Other ____
3. What is the ICD code? _________________
4. What is the patient's age? _________________ years
5. Does the patient have any of the following contraindications to the use of subcutaneous immune globulin (SCIG)?
   If Yes, indicate below or mark "None of the above."
   ❑ IgA deficiency with antibodies to IgA and a history of hypersensitivity
   ❑ History of anaphylaxis or severe systemic reaction to the administration of human immune globulin or product components
   ❑ Known systemic hypersensitivity to hyaluronidase or recombinant human hyaluronidase
   ❑ None of the above
6. Does the patient have any of the following risk factors for thrombosis?
   If Yes, indicate below or mark "None of the above." If None of the above, no further questions.
   ❑ Advanced age (45 years of age or older)
   ❑ Hypercoagulable condition
   ❑ Use of estrogens
   ❑ Hyperviscosity
   ❑ Prolonged immobilization
   ❑ History of venous or arterial thrombosis
   ❑ Indwelling central vascular catheter
   ❑ Cardiovascular risk factor(s)
   ❑ None of the above
7. Will the patient receive SCIG at the minimum dose and at the minimum rate of infusion practicable?
   ❑ Yes ❑ No

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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)**