Inqovi

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 1-866-249-6155**. 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:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Myelodysplastic syndromes (MDS), including chronic myelomonocytic leukemia (CMML)
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with all or at least three of the formulary medications. The formulary alternatives for the requested drug are Vidaza and Dacogen. Can the patient's treatment be switched to a formulary alternative? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   - ❑ Yes - Vidaza
   - ❑ Yes - Dacogen
   - ❑ No - Continue request for Inqovi

4. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to all or at least three of the formulary alternative(s)? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative. ❑ Yes ❑ No

   Formulary alternative(s): Vidaza and Dacogen

   If Yes, indicate the formulary alternative the patient has tried and the reason for treatment failure and skip to #6.

   Drug name: _____ Reason for treatment failure: _____

   Drug name: _____ Reason for treatment failure: _____

   Drug name: _____ Reason for treatment failure: _____

5. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): Vidaza and Dacogen? ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

If Yes, indicate the formulary alternative the patient is unable to take and describe the contraindication(s):

Drug name: _____ Contraindication: _____

Drug name: _____ Contraindication: _____

Drug name: _____ Contraindication: _____

6. Has chart note(s) or other documentation supporting the inadequate response, intolerable adverse reaction or contraindication to the necessary number of formulary alternatives been submitted? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.***
   ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

7. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, no further questions*

8. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?
   ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Vidaza and Dacogen) FDA-approved for the medical condition being treated?
   ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Vidaza and Dacogen)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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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