Luxturna

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*

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
   ❒ Biallelic RPE65 mutation-associated retinal dystrophy (*If checked, go to 2*)
   ❒ Other, please specify. _____ (*If checked, go to 2*)
2. Is there confirmation of bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations?
   ❒ Yes, *Continue to 3*
   ❒ No, *Continue to 3*
3. Please indicate which of the following genetic tests was performed to confirm bi-allelic pathogenic and/or likely pathogenic RPE65 gene mutations. ***ACTION REQUIRED***: Attach genetic test results (single gene test or multi gene panel test) confirming a genetic diagnosis of pathogenic/likely pathogenic biallelic RPE65 gene mutations.

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❒ Single gene panel test (*If checked, go to 4)*

❒ Multi gene panel test (*If checked, go to 4*)

❒ None of the above (*If checked, go to 4*)

4. Are the RPE65 gene mutations classifications based on the current American College of Medical Genetics and Genomics (ACMG) standards and guidelines for the interpretation of sequence variants?
   ❒ Yes, *Continue to 5*
   ❒ No, *Continue to 5*
5. Please provide the date of the genetic test.

   ❒ Date: _____MM/DD/YY (*If checked, go to 6*)

   ❒ Unknown (*If checked, go to 6*)
6. Has pathogenicity of the RPE65 mutations been affirmed within the last 12 months?
   ❒ Yes, *Continue to 7*
   ❒ No, *Continue to 7*
7. What is the patient's age?

   ❒ Less than 12 months of age (*If checked, go to 8*)

   ❒ 12 months to 64 years of age (*If checked,* go to 8)

   ❒ 65 years of age or older (*If checked, go to 8*)
8. Which of the following test(s) was performed to confirm that the patient has viable retinal cells in each eye to be treated?

   ❒ Optical coherence tomography (OCT) (*If checked, go to 9*)

   ❒ Ophthalmoscopy (*If checked, go to 9*)

   ❒ Optical coherence tomography (OCT) and ophthalmoscopy (*If checked, go to 9*)

   ❒ None of the above (*If checked, go to 9*
9. Does the patient have an area of the retina within the posterior pole of greater than 100 micrometer thickness shown on optical coherence tomography (OCT)?

   ❒ Yes (*If checked, go to 12*)

   ❒ No (*If checked, go to 10*)

   ❒ Unknown (*If checked, go to 10*)
10. Within the posterior pole, how many disc areas of the retina are without atrophy or pigmentary degeneration?

    ❒ 3 or more (*If checked, go to 12*)

    ❒ Less than 3 (*If checked, go to 11*)

    ❒ Unknown (*If checked, go to 11)*
11. Is the patient's remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent?

    ❒ Yes (*If checked, go to 12*)

    ❒ No (*If checked, go to 12*)

    ❒ Unknown (*If checked, go to 12*)
12. Has the patient had the requested drug in the past?
    ❒ Yes, *Continue to 13*
    ❒ No, *No Further Questions*
13. Please select the eye which was treated in the past.

    ❒ Right eye (*If checked, go to 14*)

    ❒ Left eye (*If checked, go to 15*)

    ❒ Both eyes (*If checked, no further questions*)
14. Is this request for a right eye treatment?

    ❒ Yes, right eye (*If checked, no further questions*)

    ❒ No, left eye (*If checked, no further questions)*

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15. Is this request for a left eye treatment?

❒ Yes, left eye (*If checked, no further questions*)

❒ No, right eye (*If checked, no further questions*)

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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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