Nulibry

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?
   ❒ Molybdenum cofactor deficiency (MoCD) Type A (*If checked, go to 2*)
   ❒ Other, please specify. _____ (*If checked, go to 2*)
2. Is this request for initiation or continuation of therapy?
   ❒ Initiation of therapy (*If checked, go to 3*)
   ❒ Continuation of therapy *(If checked, go to 6*)
3. Was the diagnosis of MoCD Type A confirmed by genetic testing confirming a mutation in the molybdenum cofactor synthesis gene 1 (MOSC1)? ***ACTION REQUIRED***: If yes, please attach genetic testing results documenting a mutation in the molybdenum cofactor synthesis gene 1 (MOSC1).

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

❒ Yes, *Continue to 9*
❒ No, *Continue to 4*

4. Does the patient have a presumed diagnosis of MoCD Type A and genetic test results are pending?
   ❒ Yes, *Continue to 5*
   ❒ No, *Continue to 5*
5. Does the patient have clinical signs and symptoms associated with MoCD Type A (e.g., encephalopathy, intractable seizures, developmental delay, decreased uric acid levels, elevated urinary S-sulfocysteine and/or xanthine levels)?
   ❒ Yes, *Continue to 9*
   ❒ No, *Continue to 9*
6. Has the patient received less than 12 months of therapy?
   ❒ Yes, *Continue to 7*
   ❒ No, *Continue to 8*
7. Has genetic testing been completed to confirm a mutation in the molybdenum cofactor synthesis gene 1 (MOSC1)? ***ACTION REQUIRED***: If yes, please attach genetic testing results documenting a mutation in the molybdenum cofactor synthesis gene 1 (MOSC1). ***ACTION REQUIRED***: Submit supporting documentation
   ❒ Yes, *Continue to 9*
   ❒ No, *Continue to 9*
8. Has the patient received 12 months of therapy or more and is experiencing benefit from therapy (e.g., improvement, stabilization, or slowing of disease progression for encephalopathy, seizure activity, improved or normalized uric acid, urinary S-sulfocysteine and xanthine levels)? ***ACTION REQUIRED***: If yes, please attach chart notes or medical records documenting a benefit from therapy (e.g., improvement, stabilization, or slowing of disease progression for encephalopathy, seizure activity, improved or normalized uric acid, urinary S-sulfocysteine, and xanthine levels). ***ACTION REQUIRED***: Submit supporting documentation
   ❒ Yes, *Continue to 9*
   ❒ No, *Continue to 9*
9. What is the patient's weight in kilograms?
   _____ kg (*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