

**Stimate
 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 drug is being prescribed? Stimate Other _____
2. What is the patient's diagnosis?

<input type="checkbox"/> Hemophilia A	<input type="checkbox"/> Qualitative platelet disorder
<input type="checkbox"/> von Willebrand disease (VWD)	<input type="checkbox"/> Menorrhagia associated with a bleeding disorder
<input type="checkbox"/> Acquired von Willebrand Syndrome (AVWS)	<input type="checkbox"/> Carriers of hemophilia A (factor VIII levels of 5-50%)
<input type="checkbox"/> Acquired hemophilia A	<input type="checkbox"/> Other _____
3. What is the ICD code? _____

Section A: Hemophilia A

4. What is the patient's factor VIII activity level (% activity): _____ %

Section B: von Willebrand disease

5. What type of von Willebrand disease does the patient have?
 Type 1 Type 2A Type 2M Type 2N Other _____
6. *If patient has Type 1*, does the patient have mild to moderate disease? Yes No
7. *If patient has any Type 2*, is the patient currently receiving therapy with Stimate?
 Yes No *If No, no further questions*
8. Has the patient shown to be responsive to Stimate with a Stimate trial? Yes No

Section C: Acquired hemophilia A

9. Does the patient have low levels of inhibitors? Yes No
10. Does the patient have mild to moderate hemorrhage? Yes No

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Stimate SGM – 3/2016.

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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)