**Member Name:** {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

# Strensiq

## 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:** {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
**Patient's ID:** {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
**Physician's Name:** {{PHYFIRST}} {{PHYLAST}}
**Specialty:** _____, **NPI#:** _____
**Physician Office Telephone:** {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
**Request Initiated For:** {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Hypophosphatasia
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. When was the onset of the diagnosis?
   - ❑ Perinatal/infantile-onset
   - ❑ Juvenile-onset
   - ❑ Adult-onset
   - ❑ Other _____
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? *If Yes, or Unknown, skip to #7.* ❑ Yes ❑ No ❑ Unknown
6. Did the patient experience benefit from therapy (e.g., improvement in skeletal manifestations, growth, gait/mobility, muscle strength) since starting the requested medication? ❑ Yes ❑ No *No further questions.*
7. Did the patient demonstrate clinical signs and symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures) before the age of 18? ***ACTION REQUIRED: If Yes, please submit medical record documentation showing presence of condition before the age of 18.*** ❑ Yes ❑ No
8. Does the patient currently demonstrate clinical signs and/or symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures)? ❑ Yes ❑ No
9. Did the patient test positive for a known pathological mutation in the ALPL gene as determined by molecular genetic testing? ***ACTION REQUIRED: If Yes, please submit genetic test results.*** ❑ Yes ❑ No
10. Do findings on radiographic imaging at the time of diagnosis support the diagnosis of hypophosphatasia (e.g., infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age [as detected by DEXA])? ***ACTION REQUIRED: If Yes, please submit radiographic imaging results.*** ❑ Yes ❑ No ❑ Not performed

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

11. How does the patient's **pretreatment** serum alkaline phosphatase (ALP) level compare to the laboratory's reference normal range based on age and gender? ***ACTION REQUIRED: Please submit laboratory test results.***
    - ❑ Higher than the laboratory's normal range
    - ❑ Lower than the laboratory's normal range
    - ❑ Within the laboratory's normal range

12. Does the patient have an elevated **pretreatment** level of a tissue-nonspecific alkaline phosphatase (TNSALP) substrate (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])? ***ACTION REQUIRED: If Yes, please submit laboratory test results.*** ❑ 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)**

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