

Tretten
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? Tretten Other _____
2. What is the patient's diagnosis?
 Congenital factor XIII deficiency
 Other _____
3. What is the ICD code? _____
4. Has deficiency of Factor XIII **A-subunit** been confirmed with BOTH of the following? Yes No
ACTION REQUIRED: *If Yes, attach laboratory documentation of specific factor XIII assay(s) and genotyping test result.*
 - a. Specific factor XIII assay(s) (e.g., enzyme-linked immunosorbent assay [ELISA]), **AND**
 - b. Genotyping
5. Is documentation of BOTH of the following attached to the request? Yes No
6. Has deficiency of Factor XIII **A-subunit** been confirmed by an increase in Factor XIII activity following administration of a test dose of Tretten? Yes No
ACTION REQUIRED: *If Yes, attach laboratory documentation of specific factor XIII assay(s) prior to and following administration of a test dose of Tretten.*
7. Is laboratory documentation of specific factor XIII assay(s) prior to and following administration of a test dose of Tretten attached to the request? Yes No
8. Will a test dose be given to confirm Factor XIII **A-subunit** deficiency? 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. Tretten 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)