CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

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

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)**