

**Xermelo (for Maryland only)**  
**Prior Authorization Request**

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

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.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's ID: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Physician Office Telephone: \_\_\_\_\_ Physician Office Fax: \_\_\_\_\_  
Request Initiated For: \_\_\_\_\_

1. What is the reason for requesting Xermelo?  
 Treatment of carcinoid syndrome diarrhea  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Would the prescriber like to request an override of the step therapy requirement?  Yes  No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?  
***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***  Yes  No
5. Is the medication effective in treating the member's condition?  Yes  No *Continue to #6 and complete this form in its entirety.*
6. Has the patient had an inadequate response to somatostatin analog therapy (eg, octreotide, lanreotide)?  
 Yes  No
7. Will Xermelo be used in combination with somatostatin analog therapy?  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)**

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. Xermelo CF - 5/2017.

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