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

1. What is the diagnosis?
   ❑ Cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the requested medication been prescribed by or in consultation with a neurologist? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
5. Did the patient achieve or maintain a positive clinical response to therapy (e.g., decrease in seizures)? ***ACTION REQUIRED: If Yes, attach documentation (e.g., chart notes) that the patient has experienced a positive clinical response to therapy (e.g., decrease in seizures).***
   ❑ Yes ❑ No *No further questions.*
6. Does the patient have a confirmed pathogenic or likely pathogenic mutation in the CDKL5 gene? ***ACTION REQUIRED: If Yes, attach chart notes or medical record documentation of enzyme assay or genetic testing demonstrating pathogenic or likely pathogenic mutation in the CDKL5 gene.*** ❑ 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