CareFirst
Family of health care plans

CVS caremark™

Factor VIII Agents
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*

Exception Criteria Questions:

A. Is the requested product Helixate FS? ❑ Yes ❑ No, *skip to Clinical Criteria Questions*

B. *The preferred product for your patient's health plan is Kogenate FS. (Please note: Kogenate FS and Helixate FS are the exact same products with different labels and brand names, which are made by the same manufacturer.)* Can the patient's treatment be switched to Kogenate FS?.
❑ Yes, *skip to Clinical Criteria Questions and mark #1 as Kogenate FS* ❑ No

C. Given that Kogenate FS and Helixate FS are the same products, is there a clinical reason that the patient must use Helixate FS over Kogenate FS? ❑ Yes ❑ No

D. Is this clinical reason documented in the patient's chart? ***ACTION REQUIRED:*** **Documentation is required for approval. Provide SPECIFIC AND DETAILED chart documentation including description, date/time, and severity of the clinical reason, dosage and duration of Preferred Product trial, required intervention (if any), and relevant rests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.** ❑ Yes ❑ No

Criteria Questions:

1. What drug is being prescribed?
   - ❑ Advate
   - ❑ Helixate FS
   - ❑ Hemofil M
   - ❑ Kogenate FS
   - ❑ Monoclate-P
   - ❑ Novoeight
   - ❑ Nuwiq
   - ❑ Recombinate
   - ❑ Xyntha
   - ❑ Other _____

2. What is the patient's diagnosis?
   - ❑ Hemophilia A
   - ❑ Acquired hemophilia A
   - ❑ Other _____

3. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis.

Section A: Acquired Hemophilia A

4. Does the patient have low levels of spontaneously acquired inhibitors? ❑ Yes ❑ No

Section B: Hemophilia A

5. Indicate which applies to patient:
   ❑ Patient is factor VIII replacement therapy-naive
   ❑ Patient is established on factor VIII replacement therapy

6. What is the patient's factor VIII assay level (% activity)? _____ %
   ACTION REQUIRED: Attach baseline factor VIII assay level (% activity) for patients naïve to factor VIII replacement therapy. If 5% or less, skip to #9.

7. Has the patient had an insufficient response to desmopressin? *If Yes, skip to #9* ❑ Yes ❑ No

8. Is there a clinical reason for not trying desmopressin first? ❑ Yes ❑ No
   ***If Yes, document the reason*: _____**

9. Does the patient have inhibitors to factor VIII? ❑ Yes ❑ No *If No, no further questions.*

10. What is the most recent Bethesda (inhibitor) titer (BU): _____ BU/mL Date of result: _____
    ACTION REQUIRED: If Yes, please attach laboratory documentation of the most recent Bethesda titer.

11. Will factor VIII be used for immune tolerance induction? ❑ 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)**