

Intron A (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs 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: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?

<input type="checkbox"/> Hepatitis B virus (including Hepatitis D co-infection) <input type="checkbox"/> Hepatitis C virus <input type="checkbox"/> Condylomata acuminata <input type="checkbox"/> Chronic myelogenous leukemia (CML) <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Renal cell carcinoma (RCC) <input type="checkbox"/> Clinically aggressive follicular non-Hodgkin's lymphoma <input type="checkbox"/> Giant cell tumor of the bone <input type="checkbox"/> Other _____	<input type="checkbox"/> Systemic light chain amyloidosis <input type="checkbox"/> Desmoid tumors <input type="checkbox"/> Adult T-cell leukemia/lymphoma (ATLL) <input type="checkbox"/> Hairy cell leukemia <input type="checkbox"/> AIDS-related Kaposi's Sarcoma <input type="checkbox"/> Mycosis fungoides/Sézary syndrome <input type="checkbox"/> Polycythemia Vera
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2. What is the ICD-10 code? _____
4. Would the prescriber like to request an override of the step therapy requirement?
 Yes No *If No, skip to diagnosis section.*
5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
 Yes No ***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.)***
6. Is the medication effective in treating the member's condition? Yes No *Continue to diagnosis section and complete this form in its entirety.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Condylomata Acuminata

7. Is the patient a candidate for standard treatment options (e.g., Podofilox, Imiquimod, Cryotherapy, Podophyllin resin)? Yes No

Section B: Chronic Myelogenous Leukemia

8. Is the patient unable to tolerate kinase inhibitor(s) or is post-hematopoietic stem cell transplant? Yes No

Section C: Hepatitis B or C Virus

9. How many weeks of current course of drug therapy has the patient received? _____ weeks

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. Intron A CF - 11/2016.

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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)