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?
   - ❑ Hepatitis B virus (including Hepatitis D co-infection)
   - ❑ Hepatitis C virus
   - ❑ Condylomata acuminata
   - ❑ Chronic myelogenous leukemia (CML)
   - ❑ Malignant melanoma
   - ❑ Renal cell carcinoma (RCC)
   - ❑ Clinically aggressive follicular non-Hodgkin's lymphoma
   - ❑ Giant cell tumor of the bone
   - ❑ Systemic light chain amyloidosis
   - ❑ Desmoid tumors
   - ❑ Adult T-cell leukemia/lymphoma (ATLL)
   - ❑ Hairy cell leukemia
   - ❑ AIDS-related Kaposi's Sarcoma
   - ❑ Mycosis fungoides/Sézary syndrome
   - ❑ Polycythemia Vera
   - ❑ Other _____

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

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)**