

**NovoSeven RT (for Maryland only)  
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.

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**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*

**Criteria Questions:**

1. What is the diagnosis?  
 Congenital Factor VII deficiency  
 Hemophilia A  
 Hemophilia B  
 Acquired von Willebrand syndrome  
 Acquired hemophilia  
 Inhibitors to Factor XI  
 Glanzmann thrombasthenia  
 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 diagnosis section.*
4. 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.).**
5. Is the medication effective in treating the member's condition?  Yes  No *Continue to diagnosis section and complete this form in its entirety.*

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

Section A: Hemophilia A and Hemophilia B

6. Does the patient have inhibitors?  Yes  No
7. What is the inhibitor titer? \_\_\_\_\_ Bethesda units per milliliter (BU/mL)

Section B: Acquired von Willebrand Syndrome

8. Have other therapies (such as desmopressin, Factor VIII/von Willebrand Factor [Alphanate, Humate, Wilate]) failed to control the patient's condition?  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)**