CareFirst

The CareFirst BlueCross BlueShield family of health care plans

Ravicti® – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 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 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **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® 800-237-2767.

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

1. Which drug is being prescribed? ☐ Ravicti® ☐ Other ___________________
2. What is the patient's diagnosis?
   ☐ Urea cycle disorder ☐ Other ____
3. What is the ICD code? ______________
4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #7.
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 #7 and complete this form in its entirety.
7. What is the patient's weight? ________________ lbs / kgs ***circle one***
8. What is the patient's age? ______________ months / years ***circle one***
9. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ☐ Yes ☐ No
10. Will Ravicti be used for ***chronic management*** of urea cycle disorder? ☐ Yes ☐ No
11. Does the patient have a urea cycle disorder that cannot be managed by dietary protein restriction and/or amino acid supplementation alone? ☐ Yes ☐ No
12. Will Ravicti® be used in combination with dietary protein restriction? ☐ Yes ☐ No
13. Has the patient tried Buphenyl® (sodium phenylbutyrate)? ☐ Yes ☐ No *If No, skip to #15*
14. Has the patient experienced intolerance to prior Buphenyl® therapy? ☐ Yes ☐ No *No further questions*
15. Does the patient have a comorbid condition that prohibits a trial of Buphenyl® due to its sodium content?
    ☐ Yes ☐ No ***If Yes, document the comorbid condition:*** ____

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)**

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. Ravicti SGM – 9/2014

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