Global Medicare Advantage Medical PA

HMSAMED - Prior Authorization Request

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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____ **Drug Name:** _____
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*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

What drug is being requested? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Criteria Questions:

50. Is this request for one of the following drugs:
    a. Ajovy
    b. Takhzyro

❒ Yes, *Continue to #51*

❒ No, *Continue to #101*

51. Is the physician requesting the drug for buy and bill?
❒ Yes, *Continue to #101*
❒ No, *Close PA and re-direct to pharmacy benefit. Drug is only covered under Medicare Part B when administered under the direct supervision of a physician*

GLOBAL CRITERIA FOR APPROVAL

101. Is the drug prescribed for an FDA-approved indication?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is this request for a new start or continuation of therapy?

❒ New Start, *Continue to #106*

❒ Continuation of Therapy, *Continue to #103*

103. Was this drug previously authorized by CVS/HMSA for this member?

❒ Yes, *Continue to #104*

❒ No, *Continue to #106*

104. Is the requested drug Tepezza?

❒ Yes, *Continue to #106*

❒ No, *Continue to #105*

105. Is there evidence to support response to treatment? *Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports a response to treatment*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

106. The following documentation is required for authorization: 1) chart notes or clinical information supporting the diagnosis, and 2) proposed treatment plan. Will these be submitted by the prescriber?

❒ 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)**

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