# Global Medicare Advantage Medical PA

## HMSA - 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:** _____
**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*

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

**Criteria Questions:** What drug is being requested? _____

1. ***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
2. ***Indicate where the drug is being administered:***
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
   ❑ Office ❑ Outpatient Hospital ❑ Pharmacy
3. What is the ICD-10 code? _____
4. What is the patient's diagnosis? _____
5. Is this request for one of the following drugs:
   a. Ajovy
   b. Takhzyro
   ❑ Yes ❑ No *If No, skip to #7*
6. Is the physician requesting the drug for buy and bill? ❑ Yes ❑ No *If No, please submit a new PA request to the member's pharmacy benefit*
7. Is this request for Evenity? *If Yes, skip to #13* ❑ Yes ❑ No
8. Is the drug prescribed for an FDA-approved indication? ❑ Yes ❑ No
9. Is this request for a new start or continuation of therapy?
   ❑ New start, *skip to #12* ❑ Continuation of therapy
10. Was this drug previously authorized by CVS/HMSA for this member?
    ❑ Yes ❑ No *If No, skip to #12*
11. 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 *No further questions.*
12. 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? ***ACTION REQUIRED: Please attach requested documentation*** ❑ Yes ❑ No *No further questions*
13. Is the drug prescribed for an FDA-approved indication? ❑ Yes ❑ No
14. 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? ***ACTION REQUIRED: Please attach requested documentation*** ❑ Yes ❑ No
15. How many months of therapy has the member received? _____months

***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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