Cutaquig, Cuvitru, Hizentra, HyQvia, Xembify

HMSACOM - 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*

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 requested product?

❑ Cutaquig ❑ Cuvitru
❑ Hizentra ❑ HyQvia
❑ Xembify ❑ Other_____

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Primary immunodeficiency (includes congenital agammaglobulinemia, X-lined agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM syndrome, severe combined immunodeficiency, and Wiskott-Aldrich syndrome), *Continue to #100*
❒ Chronic inflammatory demyelinating polyneuropathy (CIDP), *Continue to #2*
❒ Measles (Rubeola) prophylaxis), *Continue to #400*
❒ Tetanus treatment and prophylaxis, *Continue to #425*
❒ Varicella prophylaxis, *Continue to #450*
❒ Other, *No Further Questions*

2. What is the requested product?

❒ Cutaquig, *No Further Questions*
❒ Cuvitru, *No Further Questions*
❒ Hizentra, *Continue to #300*
❒ HyQvia, *Continue to #300*
❒ Xembify, *No Further Questions*

Primary Immunodeficiency

100. Is this request for a new start or continuation of subcutaneous immune globulin (SCIG) therapy?

❒ New start, *Continue to #102*
❒ Continuation of therapy, *Continue to #101*

101. Was SCIG previously authorized by HMSA/CVS for this member?

❒ Yes, *Continue to #200*
❒ No, *Continue to #102*
❒ Unknown, *Continue to #102*

102. Does the member have laboratory evidence of immunoglobulin deficiency, defined as any of the following? ***Please attach a copy of the laboratory report***

- Agammaglobulinemia (total IgG less than 200 mg/dL) or
- Persistent hypogammaglobulinemia (total IgG less than 400 mg/dL, or at least two standard deviations below normal, on at least two occasions) or
- Absence of B lymphocytes

❒ Yes, *Attach documentation and Continue to #103*
❒ No, *Continue to #103*

103. Does the member have a documented inability to mount an adequate response to inciting antigens, defined as either of the following? ***Please attach a copy of the laboratory report***

- Lack of appropriate rise in antibody titer following provocation with a polysaccharide antigen. For example, an adequate response to the pneumococcal vaccine may be defined as at least a 4-fold increase in titers for at least 50% of serotypes tested, or
- Lack of appropriate rise in antibody titer following provocation with a protein antigen. For example, an adequate response to tetanus/diphtheria vaccine may be defined as less than a 4-fold rise in titers 3-4 weeks after vaccine administration.

❒ Yes, *Attach documentation and Continue to #104*
❒ No, *Continue to #104*

104. Does the member have persistent and severe infections despite treatment with prophylactic antibiotics?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Continuation Criteria

200. Has the member demonstrated a clinical response to therapy such as a reduction in bacterial infections? ***Please attach documentation supporting a clinical response to therapy***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

300. Is this request for a new start or continuation of subcutaneous immune globulin (SCIG) therapy?
❒ New start, *Continue to #302*
❒ Continuation of therapy, *Continue to #301*

301. Was SCIG previously authorized by HMSA/CVS for this member?
❒ Yes, *Continue to #350*
❒ No, *Continue to #302*
❒ Unknown, *Continue to #302*

302. Does the member have significant functional disability (prior to initiating therapy)? ***Please attach notes documenting baseline functional disability***
❒ Yes, *Attach documentation and Continue to #303*
❒ No, *Continue to #303*

303. Was the diagnosis of CIDP confirmed by slowing of nerve conduction velocity on electromyography (EMG) or nerve conduction studies (NCS)? ***Please attach a copy of the EMG/NCS report***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Continuation Criteria

350. Has the member demonstrated significant clinical improvement since starting SCIG therapy (including improvement in sensory symptoms where applicable)? ***Please attach documentation (e.g., chart notes or medical records) that document clinical improvement***
❒ Yes, *Attach documentation and Continue to #351*
❒ No, *Continue to #351*

351. What is the total duration of treatment with SCIG for CIDP?
❒ Less than 18 months, *No Further Questions*
❒ Greater than or equal to 18 months, *Continue to #352*

352. Has SCIG dose reduction or withdrawal of treatment been periodically attempted, and the effects measured, to validate continued use? ***Please attach documentation that describes an attempt to reduce the dose or withdraw treatment***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Measles (Rubeola) prophylaxis

400. Is the patient susceptible and exposed to measles less than 6 days prior to this request?
❒ Yes, *Continue to #401*

❒ No, *Continue to #401*

401. Is this request for postexposure to prevent or modify symptoms of measles (rubeola)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Tetanus treatment and prophylaxis

425. Is this request for treatment or postexposure prophylaxis of tetanus as an alternative when tetanus immune globulin (TIG) is unavailable?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Varicella prophylaxis

450. Is this request for treatment or postexposure prophylaxis of varicella in susceptible patients when varicella-zoster immune globulin (VZIG) is unavailable?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**