



## Cutaquig

### Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435**.

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](mailto: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:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **HPHC Provider ID:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Requesting Provider **HPHC Provider ID:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Provider Tax ID:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

#### **Additional Demographic Information:**

Please indicate the place of service for the requested drug:

- Ambulatory Surgical  Home  Inpatient Hospital  Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital  Office  Pharmacy

#### **Drug Information:**

**Strength/Measure** \_\_\_\_\_ **Units**  ml  Gm  mg  ea  Un  
**Directions(sig)** \_\_\_\_\_ **Route of administration** \_\_\_\_\_  
**Dosing frequency** \_\_\_\_\_

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882**

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. Cutaquig SGM – 5/2019.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**  
**Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com**

**Criteria Questions:**

1. What is the diagnosis?
  - Primary immunodeficiency (eg, common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)
  - Chronic inflammatory demyelinating polyneuropathy
  - Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Is this a request for continuation of immune globulin therapy?  Yes  No *If No, skip to #8*
4. Has the patient experienced a reduction in the frequency of bacterial infections since starting immune globulin therapy?  Yes  No
5. Does the prescriber measure trough IgG levels at least once per year?  Yes  No Not applicable for diagnosis
6. Is the most recent trough IgG level at or above the lower range of normal for age? **ACTION REQUIRED: Attach a copy of the laboratory report with a recent IgG trough level**
  - Yes, no further questions
  - No
  - Not applicable for diagnosis, no further questions
7. Will the prescriber re-evaluate the dose of immune globulin and consider a dose adjustment (when clinically appropriate)?  Yes  No  Not applicable/not clinically appropriate *No further questions*
8. What is the specific immunodeficiency disorder?
  - Severe combined immunodeficiency (SCID), *specify:* \_\_\_\_\_
  - Congenital agammaglobulinemia (eg, X-linked or autosomal recessive agammaglobulinemia)
  - Other non-SCID combined immunodeficiency disorder, *specify:* \_\_\_\_\_
  - Common variable immunodeficiency (CVID)
  - Hypogammaglobulinemia (unspecified) or other predominant antibody deficiency disorder
  - Selective IgA deficiency
  - Selective IgM deficiency
  - IgG subclass deficiency
  - Specific antibody deficiency
  - Other immunodeficiency disorder/none of the above, *specify:* \_\_\_\_\_
9. **ACTION REQUIRED:** Please indicate and attach a copy of the following **pre-treatment** laboratory information (where applicable):
  - IgG (total) level: \_\_\_\_\_ mg/dL
    - a) Is IgG (total) level within the normal reference range?  Yes  No
    - b) If No, is the IgG level greater than or equal to ( $\geq$ ) 2 SD below the mean for age?  Yes  No
  - IgG subclass levels:
    - a) IgG1 \_\_\_\_\_ mg/dL
    - b) IgG2 \_\_\_\_\_ mg/dL
    - c) IgG3 \_\_\_\_\_ mg/dL
    - d) Other \_\_\_\_\_
    - e) Are the IgG subclass levels within the normal reference range?  Yes  No
    - f) If No, is the level(s) greater than or equal to ( $\geq$ ) 2 SD below the mean for age?  Yes  No
    - g) Were IgG subclass levels measured on at least 2 different occasions?  Yes  No
  - IgA level: \_\_\_\_\_ mg/dL
    - a) Is the IgA level within the normal reference range?  Yes  No
  - IgM level: \_\_\_\_\_ mg/dL
    - a) Is the IgM level within the normal reference range?  Yes  No
10. *If diagnosis is severe combined immunodeficiency, are maternal T cells present in the circulation?*  
*If Yes, no further questions.*  Yes  No

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882**

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. Cutaguiq SGM – 5/2019.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com**

11. *If diagnosis is severe combined immunodeficiency, what is the patient's CD3 T cell count? \_\_\_\_\_ per microliter **ACTION REQUIRED: Attach a copy of the laboratory report with lymphocyte subset enumeration by flow cytometry. No further questions***
12. Has the patient demonstrated an impaired antibody response to vaccination with a pneumococcal polysaccharide vaccine? **ACTION REQUIRED: If yes, please attach a copy of the laboratory report with post-vaccination titers.**  
 Yes  No  Not applicable
13. If applicable, was the diagnosis confirmed by molecular or genetic testing? **ACTION REQUIRED: Please attach a copy of the laboratory report or other medical record that shows the results of molecular/genetic testing.**  
 Yes  No  Not applicable to diagnosis
14. Have other causes of immune deficiency been excluded (eg, drugs, infectious disease, malignancy)?  
 Yes  No  Not applicable to diagnosis
15. Does the patient have a history of recurrent bacterial infections (eg, pneumonia, otitis media, sinusitis, sepsis, gastrointestinal infections)?  Yes  No
16. Was the immune globulin therapy initiated in the hospital setting?  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)

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882**

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. Cutaquig SGM – 5/2019.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062**

**Phone: 1-844-387-1435 • Fax: 1-844-851-0882 • www.caremark.com**