



## Factor IX, Factor IX Complex 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.

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

- What drug is being prescribed?  
 Alprolix  Benefix  Ixinity  Idelvion  Rixubis  Alphanine SD  Mononine  Bebulin  
 Profilnine  Other \_\_\_\_\_
- What is the patient's diagnosis?  
 Hemophilia B  
 Bleeding due to low levels of liver-dependent coagulation factors  
 Factor X deficiency  
 Factor II deficiency  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_

**Complete the following section if patient's diagnosis is Hemophilia B.**

Section A: Hemophilia B

- Does the patient have inhibitors to factor IX?  Yes  No *If No, no further questions.*
- What is the most recent Bethesda (inhibitor) titer (BU): \_\_\_\_\_ BU/mL Date of result: \_\_\_\_\_  
**ACTION REQUIRED: If Yes, attach laboratory documentation of the most recent Bethesda titer.**

***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. Hemo - Factor IX, IX Complex SGM - 6/2016.

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