



## 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.

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 \_\_\_\_\_

### Criteria Questions:

- 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? \_\_\_\_\_

**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 - 04/2018.

**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**

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

Section A: Hemophilia B

4. Does the patient have inhibitors to factor IX?  Yes  No *If No, no further questions.*

5. 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)**

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