Radicava

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. 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:

1. What is the diagnosis?
   ❑ Amyotrophic lateral sclerosis (ALS)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the diagnosis classified as "definite" or "probable" ALS using the Revised EL Escorial and Airlie House criteria?
   ❑ Yes ❑ No
4. Is Radicava prescribed by, or in consultation with, a neuromuscular specialist? ❑ Yes ❑ No
5. Is this request for continuation of therapy with Radicava? ❑ Yes, *skip to #10* ❑ No
6. Was the prescription performed or certified by a neurologist specializing in the diagnosis and treatment of ALS?
   ❑ Yes ❑ No
7. What is the duration of ALS disease symptoms (ie, time since first symptom of ALS)? _____Months

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

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8. Is the patient's functional ability rated at least **two** on the ALS Functional Rating Scale-Revised (ALSFRS-R) for all assessed activities of daily living (ADLs) at the time of assessment for treatment? ❑ Yes ❑ No

9. Does the patient require either noninvasive or invasive ventilatory support? *Note: No requirement for ventilatory support is indicated by a forced vital lung capacity of at least 80% at the time of assessment for treatment.*
❑ Yes ❑ No *No Further Questions*

10. Is treatment with Radicava providing a clinical benefit such as stabilization of functional ability or maintenance of activities of daily living (ADLs)? ❑ Yes ❑ No

11. Does the patient require invasive ventilatory support (eg, tracheostomy and mechanical ventilation)? ❑ 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)**

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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