Synribo

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**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider 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 Prior Authorization Fax: 1-844-851-0882

Criteria Questions:

1. What is the diagnosis?
   ❑ Chronic myeloid leukemia (CML), *where the diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene by cytogenetic and/or molecular testing*
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient received a hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML), *where the diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene by cytogenetic and/or molecular testing)*? *If Yes, no further questions* ❑ Yes ❑ No
4. Does the patient have accelerated phase CML? *If Yes, no further questions* ❑ Yes ❑ No
5. Has the patient tested positive for T315I mutation? *If Yes, no further questions* ❑ Yes ❑ No
6. Has the patient received prior therapy with two or more tyrosine kinase inhibitors (TKIs) (e.g., imatinib [Gleevec], dasatinib [Sprycel], nilotinib [Tasigna], bosutinib [Bosulif], ponatinib [Iclusig])? ❑ Yes ❑ No
7. Did the patient experience resistance, toxicity, or intolerance to prior therapy with TKIs? ❑ 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 Prior Authorization Fax: 1-844-851-0882