CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Eloctate® – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

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

1. What drug is being prescribed? ☐ Eloctate® ☐ Other _____
2. What is the diagnosis? ☐ Hemophilia A ☐ Other _____
3. What is the ICD code? _____
4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If No, skip to #7
5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)
6. Is the medication effective in treating the member's condition? ☐ Yes ☐ No Continue to #7 and complete entire form.
7. What is the patient's factor VIII assay level (% activity)? _____ % If 5% or less, skip to #10
8. Has the patient had an insufficient response to desmopressin? ☐ Yes ☐ No If Yes, skip to #10
9. Is there a clinical reason for not trying desmopressin first? Indicate below or mark "None of the above"
   - ☐ Age less than 2 years
   - ☐ Pregnancy
   - ☐ Fluid/electrolyte imbalance
   - ☐ Predisposition to thrombus formation
   - ☐ High risk for cardiovascular or cerebrovascular disease (especially the elderly)
   - ☐ Trauma requiring surgery
   - ☐ Life-threatening bleed
   - ☐ Contraindication or intolerance to desmopressin
   - ☐ Other _____
   - ☐ None of the above
10. Does the patient have inhibitors to factor VIII? ☐ Yes ☐ No If No, no further questions
11. What is the most recent Bethesda (inhibitor) titer (BU): _____ BU/mL Date of result: _____
12. Will factor VIII be used for immune tolerance induction? ☐ 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)**