Send completed form to:
Case Review Unit
CVS Caremark Specialty Programs
Fax: 1-866-249-6155

Prior Authorization Form

GamaSTAN

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient Name: _____ **Date**: _____

Patient's ID _____ **Patient's Date of Birth:** _____

Physician's Name: _____, **Specialty:** _____

Physician Office Telephone: _____ **Physician Office Fax:** _____

Physician Office Address: _____

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1. Which drug is being prescribed? ❑ GamaSTAN ❑ Other _____
2. What is the intended use for GamaSTAN?
   ❑ Prophylaxis of serious infections ❑ Prophylaxis of varicella (chickenpox)
   ❑ Prophylaxis of hepatitis A ❑ Prophylaxis of rubella
   ❑ Prophylaxis of measles (rubeola) ❑ Other _____
3. What is the ICD9? _____
4. Does the patient have any of the following contraindications to the use of GamaSTAN?
   ❑ Yes ❑ No
   - Isolated IgA deficiency
   - Severe thrombocytopenia or any coagulation disorder that the prevents use of intramuscular injections

Complete the section below designated for the intended use for GamaSTAN

SECTION A: Prophylaxis of serious infections

5. Does the patient have a diagnosis of immunoglobulin deficiency or primary immunodeficiency disease (eg, common variable immunodeficiency [CVID], X-linked agammaglobulinemia, severe combined immunodeficiency, Wiskott-Aldrich syndrome)? ❑ Yes ❑ No

SECTION B: Prophylaxis of hepatitis A

6. Has the patient been exposed to hepatitis A virus within the past 2 weeks? ❑ Yes ❑ No
7. Is the patient at high risk for exposure to hepatitis A virus? ❑ Yes ❑ No

SECTION C: Prophylaxis of measles (rubeola)

8. Has the patient been exposed to measles within the past 6 days? ❑ Yes ❑ No

SECTION D: Prophylaxis of varicella (chickenpox)

9. Has the patient recently been exposed to varicella? ❑ Yes ❑ No

Patient Name: _____ **Date**: _____

Patient's ID _____ **Patient's Date of Birth:** _____

10. Is the patient immunocompromised? ❑ Yes ❑ No **If no, skip to # 15*

11. Is varicella zoster immune globulin currently **NOT** available? ❑ Yes ❑ No

SECTION E: Prophylaxis of rubella

12. Has the patient recently been exposed to rubella? ❑ Yes ❑ No

13. Is the patient a pregnant woman? ❑ Yes ❑ No

Information given on this form is accurate as of this date:

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**