PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Chronic granulomatous disease (CGD) (If checked, go to 2) ☐
   - Severe, malignant osteopetrosis (SMO) (If checked, go to 3) ☐
   - Mycosis fungoides (type of cutaneous T-cell lymphoma) (If checked, go to 4) ☐
   - Sezary syndrome (type of cutaneous T-cell lymphoma) (If checked, go to 4) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by or in consultation with an immunologist or prescriber who specializes in the management of chronic granulomatous disease (CGD)? **Y** ☐ **N** ☐
3. Is the requested drug prescribed by or in consultation with an endocrinologist? **Y** ☐ **N** ☐
4. Is the requested drug prescribed by or in consultation with a hematologist or oncologist? **Y** ☐ **N** ☐
5. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
6. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement? **Y** ☐ **N** ☐
7. What is the diagnosis?
   - Chronic granulomatous disease (CGD) (If checked, go to 8) ☐
   - Severe, malignant osteopetrosis (SMO) (If checked, go to 9) ☐
   - Mycosis fungoides (type of cutaneous T-cell lymphoma) ☐
   - Sezary syndrome (type of cutaneous T-cell lymphoma) ☐
8. Will the requested drug be used to reduce the frequency and severity of infections associated with the patient's disease? **Y** ☐ **N** ☐
9. Will the requested drug be used to delay time to disease progression? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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