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:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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?
   - Niemann-Pick disease, type C (NPC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the requested drug be prescribed by or in consultation with an endocrinologist or physician who specializes in the treatment of metabolic disease and/or lysosomal storage disorders? **Y** ☐ **N** ☐

3. What is the patient's age?
   - 4 to 64 years of age (If checked, go to 4) ☐
   - Less than 4 years of age (If checked, no further questions) ☐
   - Greater than 64 years of age (If checked, no further questions) ☐

4. What is the patient's weight?
   - Greater than or equal to 15 kg (kilograms) (If checked, go to 5) ☐
   - Less than 15 kg (kilograms) (If checked, no further questions) ☐

5. Has the patient completed the NPC clinical severity scale (NPCCSS) assessment to establish a baseline score? ACTION REQUIRED: If Yes, please attach medical records (e.g., chart notes) of the baseline assessment for the 5-domain NPC clinical severity scale (NPCCSS) to establish baseline score. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Was the diagnosis of Niemann-Pick disease, type C confirmed by genetic testing results showing a variant in both alleles of NPC1 or NPC2 genes? ACTION REQUIRED: If Yes, attach supporting genetic or molecular test results confirming the diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Was the diagnosis of Niemann-Pick disease, type C confirmed by a mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane-triol level (>2 times the upper limit of normal)? ACTION REQUIRED: If Yes, attach supporting genetic or molecular test results confirming the diagnosis. **Y** ☐ **N** ☐
   Note: Submit supporting documentation

8. Does the patient have neurological manifestations of disease (e.g., loss of fine motor skills, swallowing, speech, ambulation)? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes) documenting neurological manifestations of disease. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Will the requested medication be used in combination with Miplyffa (arimoclomol) for the treatment of neurological manifestations of Niemann-Pick disease type C? **Y** ☐ **N** ☐

10. Is this request for initiation of therapy or continuation?

Initiation (If checked, no further questions) ☐

Continuation (If checked, go to 11) ☐

11. Is the patient experiencing benefit from therapy (e.g., stabilization or improvement in 5-domain NPCCSS score, fine motor skills, swallowing, speech, ambulation)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting positive clinical response (e.g., stabilization or improvement in 5-domain NPCCSS score, fine motor skills, swallowing, speech, ambulation). **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

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