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?
   - Mycobacterium avium complex (MAC) lung disease (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
3. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement (e.g., achievement and maintenance of negative sputum cultures)? **Y** ☐ **N** ☐
4. Does the patient have refractory disease with limited or no other treatment options? **Y** ☐ **N** ☐
5. Will the requested drug be used as a part of a combination antibacterial drug regimen? **Y** ☐ **N** ☐
6. Did the patient achieve negative sputum cultures after being treated with a multidrug background regimen for a minimum of 6 consecutive months? **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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