PA Request Criteria

00-000000000

215119

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:** 10/9/2024

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?
   - Tardive dyskinesia (If checked, go to 2) ☐
   - Chorea associated with Huntington's disease (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

3. Is the patient currently receiving the requested drug through samples (including starter pack obtained from a healthcare professional) or a manufacturer's patient assistance program?
   - Yes (If checked, go to 5) ☐
   - No (If checked, go to 4) ☐
   - Unknown (If checked, go to 5) ☐

4. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement? **Y** ☐ **N** ☐

5. What is the diagnosis?
   - Tardive dyskinesia (If checked, go to 6) ☐
   - Chorea associated with Huntington's disease (If checked, go to 8) ☐

6. Does the patient exhibit clinical manifestations of disease? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of clinical manifestations of disease. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Has the patient's tardive dyskinesia been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS])? **Y** ☐ **N** ☐

8. Does the patient demonstrate characteristic motor examination features? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of characteristic motor examination features. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Is the patient's diagnosis supported by laboratory results demonstrating an expanded HTT CAG repeat sequence of at least 36? **Y** ☐ **N** ☐

10. Does the patient have a positive family history for Huntington's disease? **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