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:** 10/9/2024
**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 patient's diagnosis?
   - Obstructive hypertrophic cardiomyopathy (If checked, go to 2) ☐
   - Other, please specify: (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving the requested medication? **Y** ☐ **N** ☐

3. Does the patient have left ventricular wall thickness of greater than or equal to 15 millimeters (mm) anywhere in the left ventricle? ACTION REQUIRED: If Yes, attach imaging reports, chart notes, or medical record documentation supporting left ventricular wall thickness. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

4. Does the patient have a left ventricular wall thickness greater than or equal to 13 mm anywhere in the left ventricle? ACTION REQUIRED: If Yes, attach imaging reports, chart notes, or medical record documentation supporting left ventricular wall thickness. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Does the patient have familial hypertrophic cardiomyopathy or a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants)? ACTION REQUIRED: If Yes, attach laboratory results, chart notes, or medical record documentation of familial hypertrophic cardiomyopathy or a positive genetic test (e.g., MYH7, MYBPC3, TNNI3, TNNT2, TPM1, MYL2, MYL3, ACTC1 gene variants). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Does the patient have New York Heart Association (NYHA) functional class II to class III symptoms? **Y** ☐ **N** ☐

7. Does the patient have a baseline left ventricular ejection fraction (LVEF) greater than or equal to 55%? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting baseline LVEF is greater than or equal to 55%. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Does the patient have a baseline Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 millimeters of mercury (mmHg)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting baseline Valsalva left ventricular outflow tract (LVOT) peak gradient is greater than or equal to 50 mmHg. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Has the patient experienced an inadequate response to a beta-adrenergic antagonist (e.g., atenolol, metoprolol) or non-dihydropyridine calcium channel blocker (diltiazem, verapamil) at maximally tolerated dose? **Y** ☐ **N** ☐

10. Does the patient have an intolerance or contraindication to both beta-adrenergic antagonist (e.g., atenolol, metoprolol) and non-dihydropyridine calcium channel blocker (diltiazem, verapamil)? **Y** ☐ **N** ☐

11. Has the patient achieved or maintained a positive clinical response to therapy (e.g., increase in pVO2, New York Heart Association [NYHA] class reduction)? ACTION REQUIRED: If Yes, attach chart notes or medical documentation supporting positive clinical response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

12. Does the patient have a left ventricular ejection fraction (LVEF) greater than or equal to 50%? ACTION REQUIRED: If Yes, attach chart notes or medical documentation supporting left ventricular ejection fraction (LVEF) greater than or equal to 50%. **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.

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**Prescriber (Or Authorized) Signature and Date**