PA Request Criteria

00-000000000

230136

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 patient's diagnosis?
   - Methylmalonic acidemia (If checked, go to 2) ☐
   - N-acetylglutamate synthase (NAGS) deficiency (If checked, go to 2) ☐
   - Propionic acidemia (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 a physician who specializes in the treatment of enzyme or metabolic disorders? **Y** ☐ **N** ☐

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

4. Is the patient experiencing benefit from therapy as evidenced by a decrease in ammonia levels from baseline? ACTION REQUIRED: If Yes, attach lab results documenting a reduction in plasma ammonia levels from baseline. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?
   - Yes, disease stability (If checked, no further questions) ☐
   - Yes, disease improvement (If checked, no further questions) ☐
   - No, neither disease stability nor disease improvement (If checked, no further questions) ☐

6. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ACTION REQUIRED: If Yes, attach enzyme assay, biochemical or genetic testing results supporting the diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Does the patient have elevated plasma ammonia levels at baseline? ACTION REQUIRED: If Yes, attach lab results documenting baseline plasma ammonia levels. **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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.