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:** 9/6/2024
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?
   - Radiolucent stones in a well-opacifying gallbladder (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 there evidence of unacceptable toxicity while receiving treatment with the requested drug? **Y** ☐ **N** ☐
4. Has the patient experienced partial (or complete) dissolution of stones? **Y** ☐ **N** ☐
5. Will the provider discontinue therapy with the requested drug if response is not seen by 18 months of treatment? **Y** ☐ **N** ☐
6. What is the patient's current weight in kilograms? Indicate patient's current weight in kilograms.
   - Any weight, please specify. (If checked, go to 7) ☐
     _____
   - Unknown (If checked, no further questions) ☐
7. Will the dose exceed 16 milligrams per kilogram per day (mg/kg/day)? Indicate dose in mg/kg/day. **Y** ☐ **N** ☐
   _____
8. How many cumulative months of therapy has the patient received?
   - Less than 24 months (If checked, no further questions) ☐
     _____
   - 24 months or more (If checked, no further questions) ☐
     _____
9. Does the patient have an increased surgical risk due to systemic disease or age? **Y** ☐ **N** ☐
10. Has the patient experienced an inadequate treatment response or intolerance to ursodiol? **Y** ☐ **N** ☐
    ACTION REQUIRED: If Yes, attach supporting chart note(s).
    ACTION REQUIRED: Submit supporting documentation

11. What is the patient's current weight in kilograms? Indicate patient's current weight in kilograms.

Any weight, please specify (If checked, go to 12) ☐

_____

Unknown (If checked, no further questions) ☐

12. Will the dose exceed 16 milligrams per kilogram per day (mg/kg/day)? Indicate dose in mg/kg/day. **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