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 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?
   - Bile acid synthesis disorders due to single enzyme defects (SEDs) (If checked, go to 7) ☐
   - Peroxisomal disorders (PDs), including Zellweger spectrum disorders (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 the requested drug being requested for use as adjunctive treatment of peroxisomal disorders (PDs)? **Y** ☐ **N** ☐
4. Is this request for continuation of therapy with the requested drug, which the patient is receiving via a pharmacy or medical benefit? **Y** ☐ **N** ☐
5. Was the diagnosis confirmed by mass spectrometry or other biochemical testing, or genetic testing? ACTION REQUIRED: If Yes, attach mass spectrometry, biochemical testing results, or genetic testing results confirming diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
6. Does the patient exhibit manifestations of liver disease (i.e., elevated transaminases, elevated bilirubin, presence of cholestasis)? ACTION REQUIRED: If Yes, attach lab test results documenting baseline liver function (i.e., transaminases, bilirubin, presence of cholestasis). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
7. Will the requested drug be prescribed by or consultation with a physician who specializes in the treatment of enzyme or metabolic disorders? **Y** ☐ **N** ☐
8. Is this request for continuation of therapy with the requested drug, which the patient is receiving via a pharmacy or medical benefit? **Y** ☐ **N** ☐
9. Was the diagnosis confirmed by mass spectrometry or other biochemical testing, genetic testing, or enzyme assay? ACTION REQUIRED: If Yes, attach mass spectrometry, enzyme assay, biochemical testing results, or genetic testing results confirming diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
10. Does the patient have liver dysfunction (i.e., elevated transaminases, elevated bilirubin, presence of cholestasis) at baseline? ACTION REQUIRED: If Yes, attach lab test results documenting baseline liver function (i.e., transaminases, bilirubin, presence of cholestasis). **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

11. Has the patient achieved and maintained improvement in liver function from baseline (i.e., reduced transaminases, reduced bilirubin, no evidence of cholestasis on liver biopsy)? **Y** ☐ **N** ☐
ACTION REQUIRED: If Yes, attach lab results documenting an improvement in liver function (i.e., reduced transaminases, reduced bilirubin, no evidence of cholestasis on liver biopsy).
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