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:** 3/31/2025
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 diagnosis?
   - Classic congenital adrenal hyperplasia (If checked, go to 2) ☐
   - Nonclassic congential adrenal hyperplasia (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the diagnosis of classic congential adrenal hyperplasia (CAH) due to any other known forms of CAH other than 21-hydroxylase deficiency (e.g., 11-beta-hydroxylase deficiency, 17-alpha-hydroxylase deficiency)?
   - Yes (If checked, no further questions) ☐
   - No (If checked, go to 3) ☐
   - Unknown (If checked, no further questions) ☐

3. Does the patient have a history of bilateral adrenalectomy, hypopituitarism, or other condition requiring chronic glucocorticoid therapy? **Y** ☐ **N** ☐

4. Is the requested drug being prescribed by or in consultation with an endocrinologist? **Y** ☐ **N** ☐

5. Is the patient currently receiving therapy with the requested drug? **Y** ☐ **N** ☐

6. Has the patient achieved or maintained a positive clinical response to treatment (e.g., reduction in glucocorticoid therapy)? ACTION REQUIRED: If yes, attach chart notes or medical record documentation confirming the member demonstrates a beneficial response to treatment. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Is the diagnosis of classic congenital adrenal hyperplasia confirmed by genetic testing?
   - Yes (If checked, go to 8) ☐
   - No (If checked, go to 9) ☐
   - Unknown (If checked, go to 9) ☐

8. Did the genetic test confirm the presence of pathogenic variants in CYP21A2? ACTION REQUIRED: If yes, please attached genetic testing report, chart notes, or medical record documentation. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

9. Have lab tests been performed to confirm a 21-hydroxylase deficiency [e.g., baseline morning serum 17-hydroxyprogesterone (17-OHP) measurement by liquid chromatography-tandem mass spectrometry (LC-MS/MS), cosyntropin (ACTH) stimulation test, adrenal steroid profile]? ACTION REQUIRED: If yes, please attach supporting chart notes or medical record documentation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

10. Is the patient currently receiving glucocorticoid therapy and stable for at least 1 month? ACTION REQUIRED: If yes, attach any chart notes, medical record documentation, or claims history supporting current utilization of glucocorticoid therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

11. Is the patient 4 years of age or older? **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