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 patient's diagnosis?
   - Paraganglioma (If checked, go to 2) ☐
   - Pheochromocytoma (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the request for a continuation of therapy with the requested medication? **Y** ☐ **N** ☐

3. Does the patient have improvement in symptoms (e.g., blood pressure, heart rate, headaches, sweating, anxiety) while on the current regimen? **Y** ☐ **N** ☐

4. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

5. Has the patient experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist (e.g., terazosin, doxazosin, prazosin, phenoxybenzamine)? **Y** ☐ **N** ☐

6. What is the clinical setting in which the requested medication will be used?
   - The requested medication will be used for preoperative preparation for surgery (If checked, no further questions) ☐
   - The requested medication will be used for management when surgery is contraindicated (If checked, no further questions) ☐
   - The requested medication be used chronic treatment for malignant pheochromocytoma (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

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