PA Request Criteria

00-000000000

230130

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?
   - Long-chain fatty acid oxidation disorders (LC-FAOD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Which of the following diagnoses does the patient have?
   - Carnitine palmitoyltransferase type 1 (CPT1) deficiency (If checked, go to 3) ☐
   - Carnitine palmitoyltransferase type 2 (CPT2) deficiency (If checked, go to 3) ☐
   - Carnitine-acylcarnitine translocase (CACT) deficiency (If checked, go to 3) ☐
   - Very-long-chain acyl-CoA dehydrogenase (VLCAD) deficiency (If checked, go to 3) ☐
   - Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency (LCHAD) (If checked, go to 3) ☐
   - Trifunctional protein (TFP) deficiency (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. 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** ☐

4. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

5. Is this request for continuation of therapy with the requested drug, which the patient is receiving via a pharmacy or medical benefit? **Y** ☐ **N** ☐

6. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement (e.g., improvement in cardiomyopathy, glycemic control or exercise tolerance, or a reduction in episodes of cardiomyopathy, rhabdomyolysis, hypoglycemia or hospitalizations)? **Y** ☐ **N** ☐

7. Did the patient have the following elevated acylcarnitine levels on a newborn blood spot or in plasma, as applicable to the patients diagnosis: a) CPT1 deficiency: elevated C0; C0/C16 + C18, b) CPT2 and CACT deficiency: elevated C16 and/or C18:1, c) LCHAD and TFP deficiency: elevated C16-OH and/or C18-OH and/or other long-chain acylcarnitines, d) VLCAD deficiency: elevated C14:1 and/or other long-chain acylcarnitines? **Y** ☐ **N** ☐

8. At the time of the diagnosis, did the patient have low enzyme activity in cultured fibroblasts? ACTION REQUIRED: If Yes, attach supporting chart or laboratory documentation of low enzyme activity in cultured fibroblasts.
   ACTION REQUIRED: Submit supporting documentation
   Y ☐ **N** ☐

9. At the time of the diagnosis, did the patient have low enzyme activity in cultured fibroblasts? ACTION REQUIRED: If Yes, attach supporting chart or laboratory documentation of low enzyme activity in cultured fibroblasts.
   ACTION REQUIRED: Submit supporting documentation
   Y ☐ **N** ☐

10. Does the patient have one or more known pathogenic variant(s) in CPT1A, SLC25A20, CPT2, acyl-CoA dehydrogenase very-long-chain (ACADVL), hydroxyacyl-CoA dehydrogenase trifunctional multienzyme complex subunit alpha (HADHA) or hydroxyacyl-CoA dehydrogenase trifunctional multienzyme complex subunit beta (HADHB) gene? ACTION REQUIRED: If Yes, attach supporting chart or laboratory documentation confirming pathogenic variant(s) by genetic testing.
    ACTION REQUIRED: Submit supporting documentation
    Y ☐ **N** ☐

11. Has the patient been receiving a low-fat/high-carbohydrate diet and medium-chain triglyceride (MCT) supplementation (e.g., MCT oil supplements, specialized infant or pediatric formula supplemented with MCT for LC-FAOD such as Lipistart, Monogen, Portagen, Enfaport, MCT Procal, MCT Oil, and Liquigen)?
    Y ☐ **N** ☐

12. How many hospitalizations and ER visits has the patient had within the past year due to rhabdomyolysis, cardiomyopathy, or hypoglycemic episodes? ACTION REQUIRED: Attach supporting chart note documentation of at least one hospitalization or ER visit within the past year due to rhabdomyolysis, cardiomyopathy, or hypoglycemic episodes.

    ☐ None (If checked, no further questions)

    ☐ One or more. Please specify number of visits. (If checked, no further questions)

    _____
    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