PA Request Criteria

00-000000000

209129

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:** 8/12/2024
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?
   - Duchenne muscular dystrophy (DMD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____
2. Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)? **Y** ☐ **N** ☐
3. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
4. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 5) ☐
   - No (If checked, go to 12) ☐
   - Unknown (If checked, go to 5) ☐
5. Will the requested medication be used in combination with a corticosteroid (e.g., prednisone)? **Y** ☐ **N** ☐
6. Has the patient experienced a contraindication or intolerance to a corticosteroid (e.g., prednisone)? **Y** ☐ **N** ☐
7. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing showing a mutation in the DMD gene? ACTION REQUIRED: If Yes, attach a copy of the laboratory report confirming DMD gene mutation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
8. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by a muscle biopsy demonstrating absent dystrophin? ACTION REQUIRED: If Yes, attach a copy of the patient's medical record confirming a muscle biopsy demonstrated absent dystrophin. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
9. Is the patient ambulatory? **Y** ☐ **N** ☐
10. Is the patient 6 years of age or older? **Y** ☐ **N** ☐
11. Does the patient have clinical signs and symptoms of DMD (e.g., proximal muscle weakness, Gower's maneuver, elevated serum creatine kinase level)? **Y** ☐ **N** ☐

12. Has the patient demonstrated a response to therapy as evidenced by remaining ambulatory (e.g., able to walk with or without assistance, not wheelchair dependent)? ACTION REQUIRED: If Yes, attach chart notes and/or medical records documenting a response to therapy.
    ACTION REQUIRED: Submit supporting documentation

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