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:** 5/13/2025
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. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Dupixent, Nemluvio) or targeted synthetic drug (e.g., Cibinqo, Opzelura, Rinvoq) for the same indication? **Y** ☐ **N** ☐
2. What is the diagnosis?
   - Atopic dermatitis, moderate-to-severe (If checked, go to 3) ☐
   - Other, please specify (If checked, no further questions) ☐
     _____
3. Is the patient 12 years of age or older? **Y** ☐ **N** ☐
4. Does the patient weigh 40 kilograms (kg) or greater? **Y** ☐ **N** ☐
5. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist? **Y** ☐ **N** ☐
6. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
7. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 9) ☐
   - No (If checked, go to 8) ☐
   - Unknown (If checked, go to 9) ☐
8. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Has the patient received in the past year or is currently receiving a biologic (e.g., Adbry, Dupixent, Nemluvio) or systemic targeted synthetic drug (e.g., Cibinqo, Rinvoq) indicated for moderate-to-severe atopic dermatitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

10. What is the percentage of body surface area (BSA) affected prior to initiation of the requested drug? Please indicate BSA percentage. ACTION REQUIRED: Please attach chart note(s) or medical record documentation of body surface area affected.

    Less than 10% of BSA (If checked, go to 11) ☐

    _____

    Greater than or equal to 10% of BSA (If checked, go to 12) ☐

    _____

    ACTION REQUIRED: Submit supporting documentation

11. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of affected area(s). **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

12. Has the patient had an inadequate treatment response with a medium potency to superhigh potency topical corticosteroid in the past year? **Y** ☐ **N**

13. Is the information on the active ingredient, strength, and dosage form of the medium potency to super-high potency topical steroid the patient had an inadequate treatment response to in the past year provided? ACTION REQUIRED: Please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy.
    Yes (If checked, go to 21) ☐

    _____

    No (If checked, go to 14) ☐

    ACTION REQUIRED: Submit supporting documentation

14. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

15. Has the patient had an inadequate treatment response with a topical Janus kinase (JAK) inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

16. Has the patient had an inadequate treatment response with a topical phosphodiesterase-4 (PDE-4) inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

17. Is the use of medium potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

18. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

19. Is the use of topical Janus kinase (JAK) inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

20. Is the use of topical phsophodiesterase-4 (PDE-4) inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation
Y ☐ **N** ☐

21. Is a loading dose prescribed?
Y ☐ **N** ☐

22. Does the prescribed loading dose exceed a dose of 500 mg?
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