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:** 7/25/2025
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?
   - Atopic dermatitis, moderate-to-severe (If checked, go to 2) ☐
   - Other, please specify (If checked, no further questions) ☐
   _____
2. Is the patient 12 years of age or older? **Y** ☐ **N** ☐
3. Does the patient weigh 40 kilograms (kg) or greater? **Y** ☐ **N** ☐
4. 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** ☐
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 10) ☐
   - No (If checked, go to 8) ☐
   - Unknown (If checked, go to 10) ☐
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. Is this a request for continuation of the higher dosing regimen due to the patient not yet achieving an adequate clinical response? **Y** ☐ **N** ☐

10. Has the patient received within the past 180 days or is currently receiving a biologic (e.g., Adbry, Dupixent, Nemluvio) or systemic targeted synthetic drug (e.g., Cibinqo, Rinvoq) indicated for the treatment of 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

11. 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 12) ☐
    _____
    Greater than or equal to 10% of BSA (If checked, go to 13) ☐
    _____
    ACTION REQUIRED: Submit supporting documentation

12. 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

13. Has the patient had an inadequate treatment response with a high potency or super-high potency topical corticosteroid in the past 180 days? **Y** ☐ **N** ☐

14. Is information on the active ingredient, strength, and dosage form of the high or super-high potency topical steroid the patient had an inadequate treatment response to in the past 180 days provided? Indicate drug strength in percentage. 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, information is included (If checked, go to 22) ☐
    _____
    No, information is not included (If checked, go to 15) ☐
    ACTION REQUIRED: Submit supporting documentation

15. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past 180 days? ACTION REQUIRED: If Yes, 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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

16. Has the patient had an inadequate treatment response with a topical Janus kinase (JAK) inhibitor in the past 180 days? ACTION REQUIRED: If Yes, 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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

17. Has the patient had an inadequate treatment response with a topical phosphodiesterase-4 (PDE-4) inhibitor in the past 180 days? ACTION REQUIRED: If Yes, 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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

18. Is the use of high potency or super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? 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

19. Is the use of topical calcineurin inhibitors 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

20. 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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

21. Is the use of topical phosphodiesterase-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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

22. Is the patient currently receiving the requested drug? Y ☐ N ☐

23. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

- Yes (If checked, go to 28) ☐
- No (If checked, go to 24) ☐
- Unknown (If checked, go to 28) ☐

24. Does the prescribed dose exceed 250 mg? Y ☐ N ☐

25. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? Y ☐ N ☐

26. Is this request for a higher maintenance dose frequency due to the patient not achieving adequate clinical response? Y ☐ N ☐

27. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks? Y ☐ N ☐

28. Is a loading dose prescribed? Y ☐ N ☐

29. Does the prescribed dose exceed a loading dose of 500 mg at week 0 and week 2, followed by a maintenance dose of 250 mg thereafter? Y ☐ N ☐

30. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week? Y ☐ N ☐

31. Does the prescribed dose exceed 250 mg? Y ☐ N ☐

32. Is the prescribed frequency more frequent than one dose every other week? 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