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:** 5/29/2025

Patient ID: _____ **Patient Date Of Birth:** _____

Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____

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?

   Human immunodeficiency virus (HIV) infection (If checked, go to 2) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by or in consultation with an infectious disease specialist? **Y** ☐ **N** ☐

3. Is the requested drug requested for weight loss? **Y** ☐ **N** ☐

4. Will the requested drug be used to reduce excess abdominal fat in a patient with human immunodeficiency virus (HIV) infection and lipodystrophy? **Y** ☐ **N** ☐

5. Is the patient currently receiving antiretroviral therapy? **Y** ☐ **N** ☐

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

7. Has the patient demonstrated a clear clinical improvement from baseline that is supported by waist circumference measurement or computed tomography (CT) scan? **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