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:** 10/9/2024
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?
   - Neuromyelitis optica spectrum disorder (NMOSD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Will the requested drug be used concomitantly with other biologics for the treatment of NMOSD? **Y** ☐ **N** ☐

3. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

4. Has the patient demonstrated a positive response to therapy (e.g., reduction in number of relapses)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Is the patient anti-aquaporin-4 (AQP4) antibody positive? ACTION REQUIRED: If Yes, attach immunoassay confirming presence of anti-AQP4 antibody. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Does the patient exhibit at least one of the follow core clinical characteristics of NMOSD? Optic neuritis, Acute myelitis, Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting), Acute brainstem syndrome, Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic magnetic resonance imaging (MRI) lesions, Symptomatic cerebral syndrome with NMOSD-typical brain lesions.
   - Yes (If checked, no further questions) ☐
   - No (If checked, no further questions) ☐

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

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