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. What is the diagnosis?
   - Adult medulloblastoma (If checked, go to 6) ☐
   - Basal cell carcinoma (BCC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
3. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐
5. What is the clinical setting in which the requested drug will be used?
   - Advanced disease (If checked, no further questions) ☐
   - Diffuse disease (e.g., Gorlin syndrome) (If checked, no further questions) ☐
   - Recurrent disease (If checked, no further questions) ☐
   - Nodal disease (If checked, no further questions) ☐
   - Metastatic disease (If checked, no further questions) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
7. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

8. Does the patient have tumor(s) with mutations in the sonic hedgehog pathway? Yes (If checked, go to 9) ☐

No (If checked, no further questions) ☐
Unknown (If checked, no further questions)

9. Has the patient received chemotherapy previously? **Y** ☐ **N** ☐

10. Will the requested medication be given as a single agent therapy? **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

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