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:** 6/13/2025
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?
   - Dystrophic epidermolysis bullosa (DEB) (If checked, go to 2) ☐
   - Junctional epidermolysis bullosa (JEB) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by or in consultation with a dermatologist or wound care specialist? **Y** ☐ **N** ☐

3. What is the patient's age?
   - 6 months of age or older (If checked, go to 4) ☐
   - Less than 6 months of age (If checked, no further questions) ☐

4. Does the patient have clinical manifestations of disease (e.g., extensive skin blistering, skin erosions, scarring)? If yes, indicate clinical manifestations. ACTION REQUIRED: If yes, please attach medical records documenting clinical manifestations of disease. **Y** ☐ **N** ☐

   _____
   ACTION REQUIRED: Submit supporting documentation

5. Has the patient had laboratory tests to confirm the diagnosis (i.e., genetic testing, immunofluorescence mapping [IFM], transmission electron microscopy [TEM])? ACTION REQUIRED: If yes, please attach laboratory test results supporting diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Will the requested drug be administered to wounds that are currently healed? **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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