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:** 9/6/2024
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?
   - Lambert-Eaton myasthenic syndrome (LEMS) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Does the patient have a history of seizures? **Y** ☐ **N** ☐
3. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
4. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 5) ☐
   - No (If checked, go to 9) ☐
   - Unknown (If checked, go to 5) ☐
5. Has the diagnosis been confirmed by electromyography (EMG) showing compound muscle action potential (CMAP) that increased at least 2-fold after maximum voluntary contraction of the tested muscle OR a positive anti-P/Q type voltage-gated calcium channel antibody test? ACTION REQUIRED: If Yes, attach a copy of the laboratory report, EMG or other supporting medical record(s).
   - Yes - EMG showing CMAP that increased at least 2-fold after maximum voluntary contraction of the tested muscle. (If checked, go to 6) ☐
   - Yes - A positive anti-P/Q type voltage-gated calcium channel antibody test. (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
6. Does the patient have proximal muscle weakness? **Y** ☐ **N** ☐
7. Has the patient previously been treated with the requested medication? **Y** ☐ **N** ☐
8. What is the patient's Quantitative Myasthenia Gravis (QMG) score?
   - Less than 5 (If checked, no further questions) ☐

Greater than or equal to 5 (If checked, no further questions) ☐

9. Is the patient responding to therapy (i.e., there is stability or improvement in symptoms relative to the natural course of LEMS)? **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