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:** 1/23/2026
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?
   - Barth Syndrome (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug being prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of metabolic or neuromuscular disorders? **Y** ☐ **N** ☐

3. Is the request for continuation of therapy? **Y** ☐ **N** ☐

4. Has the patient demonstrated a response to therapy [e.g., improvement in rate of disease progression as demonstrated by distance walked on the 6-minute walk test (6MWT), the Barth Syndrome Symptom Assessment (BTHS-SA) score, muscle strength as measured by handheld dynamometry (HHD), Five Times Sit-To-Stand (5XSST) time, SWAY Application Balance Assessment, Patient Global Impression Scales of Symptoms, Clinician Global Impression (CGI)]? ACTION REQUIRED: If Yes, please attach chart notes or medical records documenting a response to therapy [e.g., improvement in rate of disease progression as demonstrated by distance walked on the 6-minute walk test (6MWT), the Barth Syndrome Symptom Assessment (BTHS-SA) score, muscle strength as measured by handheld dynamometry (HHD), Five Times Sit-To-Stand (5XSST) time, SWAY Application Balance Assessment, Patient Global Impression Scales of Symptoms, Clinician Global Impression (CGI)].
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

5. Please indicate the patient's age:
   - Less than 12 years of age (If checked, no further questions) ☐
   - 12 to less than 18 years of age (If checked, go to 6) ☐
   - 18 years of age or older (If checked, go to 7) ☐

6. Is the patient renally impaired? **Y** ☐ **N** ☐

7. What is the patient's eGFR (estimated glomerular filtration rate)?
   - Greater than or equal to 30 mL/min/1.73 m2 (If checked, go to 9) ☐
   - Less than 30 mL/min/1.73 m2 (If checked, go to 8) ☐

8. Is the patient on dialysis? **Y** ☐ **N** ☐

9.	Is the patient's weight greater than or equal to 30 kg?	**Y** ☐	**N** ☐
10.	Was the diagnosis confirmed by genetic testing documenting a pathogenic variant in the TAFAZZIN gene? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of genetic testing results supporting diagnosis. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
11.	Was the diagnosis confirmed by an increased monolysocardiolipin:cardiolipin (MLCL/CL) ratio? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of the monolysocardiolipin:cardiolipin (MLCL/CL) ratio assay results supporting diagnosis. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
12.	Has the patient completed a 6-minute walk test (6MWT) prior to the start of therapy and has been found to be ambulatory and impaired per the provider? ACTION REQUIRED: If Yes, please attach medical records (e.g., chart notes) documentation of the baseline assessment for the 6-minute walk test (6MWT) to establish baseline results. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
13.	Does the patient have uncontrolled hypertension in the opinion of the provider (i.e., blood pressure consistently elevated above 160 mmHg systolic or 100 mmHg diastolic despite appropriate treatment)?	**Y** ☐	**N** ☐
14.	Has the patient previously undergone heart transplantation?	**Y** ☐	**N** ☐
15.	Is the patient planning to undergo heart transplantation?	**Y** ☐	**N** ☐
16.	Does the patient have an implantable cardioverter defibrillator (ICD)?	**Y** ☐	**N** ☐
17.	Has there been a known occurrence of ICD discharge in the past three months?	**Y** ☐	**N** ☐
18.	Is the patient planning to undergo an implantation of an ICD?	**Y** ☐	**N** ☐
19.	Is the patient currently receiving treatment with chemotherapeutic agents?	**Y** ☐	**N** ☐
20.	Has the patient received prior radiation therapy to the chest?	**Y** ☐	**N** ☐
21.	Has the patient received stem cell or gene therapy?	**Y** ☐	**N** ☐
22.	Is the patient currently being treated by a therapeutic investigational device?	**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