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:** 10/9/2026
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?
   - Chronic hepatitis delta virus (HDV) infection (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2.	Will the requested drug be prescribed by or in consultation with a provider experienced in the management of hepatitis D virus (HDV) infection?	**Y** ☐	**N** ☐
3.	Is the patient currently receiving treatment with the requested drug?	**Y** ☐	**N** ☐
4.	Has the patient achieved or maintained positive clinical response (e.g., decreased hepatitis delta virus [HDV] RNA level, alanine aminotransferase [ALT] normalization) since starting treatment with the requested drug?	**Y** ☐	**N** ☐
5.	Does the patient have liver cirrhosis?	**Y** ☐	**N** ☐
6.	Does the patient have compensated cirrhosis?	**Y** ☐	**N** ☐
7.	Does the patient have chronic HDV infection as confirmed by a positive serum anti-HDV antibody result?	**Y** ☐	**N** ☐
8.	Does the patient have chronic HDV infection as confirmed by a positive polymerase chain reaction (PCR) result for HDV RNA within the past 6 months? ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
9.	Has the HDV infection been present for greater than 6 months?	**Y** ☐	**N** ☐
10.	Does the patient have a pretreatment elevated serum alanine aminotransferase (ALT) level?	**Y** ☐	**N** ☐
11.	Does the patient have any current or previous decompensated liver disease (e.g., coagulopathy, hepatic encephalopathy, ascites, esophageal varices hemorrhage)?	**Y** ☐	**N** ☐
12.	Is the patient 18 years of age or older?	**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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