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:** 7/2/2026
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?
   - Acquired hypothalamic obesity (If checked, go to 2) ☐
   - Obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency (If checked, go to 16) ☐
   - Obesity due to Bardet-Biedl Syndrome (BBS) (If checked, go to 31) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. Is the requested drug being prescribed by or in consultation with an endocrinologist or a prescriber specialized in the treatment of metabolic disorders? **Y** ☐ **N** ☐

3. Does the patient have a diagnosis of Prader-Willi syndrome (PWS) or rapid-onset obesity with hypoventilation, hypothalamic, autonomic dysregulation, neuroendocrine tumor syndrome (ROHHADNET)? **Y** ☐ **N** ☐

4. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

5. How many months of therapy has the patient received?
   - 1 month (If checked, no further questions) ☐
   - 2 months (If checked, no further questions) ☐
   - 3 months (If checked, no further questions) ☐
   - 4 months (If checked, no further questions) ☐
   - 5 months (If checked, no further questions) ☐
   - 6 months (If checked, no further questions) ☐
   - 7 months (If checked, no further questions) ☐
   - 8 months (If checked, no further questions) ☐
   - 9 months (If checked, no further questions) ☐
   - 10 months (If checked, no further questions) ☐
   - 11 months (If checked, no further questions) ☐

12 months or more (If checked, go to 6) ☐

6. Has the patient had a reduction in body mass index (BMI) of at least 5% from baseline? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes) and growth chart documentation of current BMI. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

7. Has the patient achieved or sustained clinically meaningful weight loss? ACTION REQUIRED: If Yes, medical records (e.g., chart notes) and growth chart documentation of current BMI and current body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

8. Is the patient 4 years of age or older? — Y ☐ N ☐

9. Will the patient be using the requested drug to reduce excess body weight and maintain weight reduction long term? — Y ☐ N ☐

10. Has the patient experienced a traumatic or disease-related (e.g., oncological) injury to the hypothalamus detectable on magnetic resonance imaging (MRI) or computed tomography (CT) scan? ACTION REQUIRED: If Yes, please attach MRI or CT scan records documenting structural damage, lesions, or tumors in the hypothalamus. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

11. Is the patient 18 years of age or older? — Y ☐ N ☐

12. Has the patient had a rapid, clinically significant increase in body mass index (BMI) (more than or equal to 5% BMI increase) that began within the first 12 months after the onset of hypothalamic damage? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation of pretreatment BMI and body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

13. Is the patient's body mass index (BMI) 30 kilograms per meter squared (kg/m^2) or greater? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation of pretreatment BMI and body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

14. Has the patient had a rapid, clinically significant increase in body mass index (BMI) (more than or equal to 1.0 BMI standard deviation [SDS] increase in pediatric patients) that began within the first 12 months after the onset of hypothalamic damage? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation of pretreatment BMI and body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

15. Is the patient's body mass index (BMI) greater than or equal to 95th percentile for age on growth chart assessment? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation and growth chart documentation of pretreatment BMI and body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

16. Is the requested drug being prescribed by or in consultation with an endocrinologist, a geneticist, or a prescriber specialized in the treatment of metabolic disorders? — Y ☐ N ☐

17. Is the patient currently receiving treatment with the requested drug? — Y ☐ N ☐

18. Is the patient 2 years of age or older? — Y ☐ N ☐

19. How many months of therapy has the patient received?

Less than 12 months (If checked, go to 20) ☐

12 months or more (If checked, go to 23) ☐

20. Is the patient less than 18 years of age? — Y ☐ N ☐

21. Has the patient lost at least 5% of baseline body weight? ACTION REQUIRED: If Yes, attach medical record (e.g., chart notes) and documentation of current body weight. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

22. Has the patient had a reduction in body mass index (BMI) of at least 5% from baseline? ACTION REQUIRED: If Yes, attach medical record (e.g., chart notes) and growth chart documentation of current BMI. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

23. Has the patient achieved or sustained clinically meaningful weight loss? ACTION REQUIRED: If Yes, attach medical record (e.g., chart notes) and growth chart documentation of current BMI and current body weight.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

24. Will the patient be using the requested drug to reduce excess body weight and maintain weight reduction long term in obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency? — **Y** ☐ **N** ☐

25. Has the diagnosis been confirmed by genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes? ACTION REQUIRED: If Yes, attach genetic test results documenting variants (i.e., homozygous, compound heterozygous, heterozygous) in POMC, PCSK1, or LEPR genes.
    - Yes - homozygous (If checked, go to 26) ☐
    - Yes - compound heterozygous (If checked, go to 26) ☐
    - Yes - heterozygous (If checked, no further questions) ☐
    - No - unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

26. What is the POMC, PCSK1, or LEPR gene variant interpretation (e.g., pathogenic, likely pathogenic, of uncertain significance [VUS])?
    - Pathogenic (If checked, go to 27) ☐
    - Likely pathogenic (If checked, go to 27) ☐
    - Variant of uncertain significance (VUS) (If checked, go to 27) ☐
    - Risk (If checked, no further questions) ☐
    - Benign (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

27. Is the patient 2 years of age or older? — **Y** ☐ **N** ☐

28. Is the patient 18 years of age or older? — **Y** ☐ **N** ☐

29. Is the patient's body mass index (BMI) 30 kilograms per meter squared (kg/m^2) or greater? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation of pretreatment BMI and body weight.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

30. Is the patient's body mass index (BMI) greater than or equal to 95th percentile for age on growth chart assessment? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation and growth chart documentation of pretreatment BMI and body weight.
    ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

31. Is the requested drug being prescribed by or in consultation with an endocrinologist, a geneticist, or a prescriber specialized in the treatment of metabolic disorders? — **Y** ☐ **N** ☐

32. Is the patient currently receiving treatment with the requested drug? — **Y** ☐ **N** ☐

33. Is the patient 2 years of age or older? — **Y** ☐ **N** ☐

34. How many months of therapy has the patient received?
    - 1 month (If checked, no further questions) ☐
    - 2 months (If checked, no further questions) ☐
    - 3 months (If checked, no further questions) ☐
    - 4 months (If checked, no further questions) ☐
    - 5 months (If checked, no further questions) ☐
    - 6 months (If checked, no further questions) ☐

7 months (If checked, no further questions) ☐

8 months (If checked, no further questions) ☐

9 months (If checked, no further questions) ☐

10 months (If checked, no further questions) ☐

11 months (If checked, no further questions) ☐

12 months or more (If checked, go to 35) ☐

35. Is the patient less than 18 years of age? **Y** ☐ **N** ☐

36. Has the patient lost at least 5% of baseline body weight? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes) documentation of current body weight. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

37. Has the patient had a reduction in body mass index (BMI) of at least 5% from baseline? ACTION REQUIRED: If Yes, attach medical record (e.g., chart notes) and growth chart documentation of BMI. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

38. Will the patient be using the requested drug to reduce excess body weight and maintain weight reduction long term in obesity due to Bardet-Biedl syndrome (BBS)? **Y** ☐ **N** ☐

39. Does the patient have a clinical diagnosis of Bardet-Biedl syndrome (BBS)? **Y** ☐ **N** ☐

40. Does the patient have 4 primary features of Bardet-Biedl syndrome? Note: Primary features include: rod-cone dystrophy, polydactyly, obesity, learning disability, hypogonadism in males, and renal abnormalities. ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation supporting clinical diagnosis.

Yes, please specify primary features: (If checked, go to 43) ☐

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No (If checked, go to 41) ☐

ACTION REQUIRED: Submit supporting documentation

41. Does the patient have 3 primary and 2 secondary features of Bardet-Biedl syndrome? Note: Primary features include: rod-cone dystrophy, polydactyly, obesity, learning disability, hypogonadism in males, and renal abnormalities. Secondary features include: speech disorder/delay, strabismus/cataracts/astigmatism, brachydactyly/syndactyly, developmental delay, polyuria/polydipsia (nephrogenic diabetes insipidus), ataxia/poor coordination/imbalance, mild spasticity (especially lower limbs), diabetes mellitus, dental crowding/hypodontia/small roots/high arched palate, left ventricular hypertrophy/congenital heart disease, and hepatic fibrosis. ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation supporting clinical diagnosis.

Yes, please specify features: (If checked, go to 43) ☐

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No (If checked, go to 42) ☐

ACTION REQUIRED: Submit supporting documentation

42. Has the member had genetic testing confirming a variant in both alleles of one of the core genes associated with Bardet-Biedl syndrome (e.g., BBS1, BBS2, ARL6) and one primary feature of the Beales criteria? Note: Primary features include: rod-cone dystrophy, polydactyly, obesity, learning disability, hypogonadism in males, and renal abnormalities. ACTION REQUIRED: If Yes, attach chart note(s), medical record documentation, or genetic testing confirming a variant in both alleles of one of the core genes associated with BBS.

Yes, please specify genetic variation and primary BBS features: (If checked, go to 43) ☐

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No (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

43. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

44. Is the patient 18 years of age or older? **Y** ☐ **N** ☐

45. Is the patient's body mass index (BMI) 30 kilograms per meter squared (kg/m^2) or greater? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation of pretreatment BMI and body weight.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

46. Is the patient's body mass index (BMI) greater than or equal to 95th percentile for age on growth chart assessment? ACTION REQUIRED: If Yes, attach chart note(s) or medical record documentation and growth chart documentation of pretreatment BMI and body weight.
ACTION REQUIRED: Submit supporting documentation **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.

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Prescriber (Or Authorized) Signature and Date