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:** 10/10/2024
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?
   - Malignant melanoma (If checked, go to 2) ☐
   - Adult T-cell leukemia/lymphoma (ATLL) (If checked, go to 2) ☐
   - Hairy cell leukemia (If checked, go to 10) ☐
   - Follicular lymphoma, clinically aggressive (If checked, go to 2) ☐
   - Renal cell carcinoma (If checked, go to 2) ☐
   - Condylomata acuminata (If checked, go to 2) ☐
   - AIDS-related Kaposi sarcoma (If checked, go to 2) ☐
   - Chronic myeloid leukemia (CML) (If checked, go to 2) ☐
   - Chronic hepatitis B virus (including Hepatitis D co-infection) (If checked, go to 4) ☐
   - Chronic hepatitis C virus (If checked, go to 3) ☐
   - Ocular surface neoplasia (conjunctival and corneal neoplasm) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
3. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
4. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
5. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
6. Is the patient receiving clinical benefit from the requested drug while on the current regimen? **Y** ☐ **N** ☐
7. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

8. Is the patient receiving clinical benefit from the requested drug while on the current regimen? **Y** ☐ **N** ☐

9. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

10. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

11. Is the patient receiving clinical benefit from the requested drug while on the current regimen? **Y** ☐ **N** ☐

12. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐

13. What is the diagnosis?

- Malignant melanoma (If checked, no further questions) ☐
- Adult T-cell leukemia/lymphoma (ATLL) (If checked, go to 14) ☐
- Follicular lymphoma, clinically aggressive (If checked, no further questions) ☐
- Renal cell carcinoma (If checked, go to 15) ☐
- Condylomata acuminata (If checked, no further questions) ☐
- AIDS-related Kaposi sarcoma (If checked, no further questions) ☐
- Chronic myeloid leukemia (CML) (If checked, no further questions) ☐
- Ocular surface neoplasia (conjunctival and corneal neoplasm) (If checked, no further questions) ☐

14. Will the requested drug be used in combination with zidovudine? **Y** ☐ **N** ☐

15. Will the requested drug be used in combination with bevacizumab? **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