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:** 9/9/2024
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?
   - Cushing's disease (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
3. Has the patient experienced a reduction in cortisol level since the start of therapy with the requested drug as indicated by one of the following tests: A) Urinary free cortisol (UFC), B) Late-night salivary cortisol (LNSC), C) 1 mg overnight dexamethasone suppression test (DST), or D) Longer, low dose DST (2 mg per day for 48 hours)? ACTION REQUIRED: If Yes, attach lab report with current cortisol level.
   - Yes (If checked, no further questions) ☐
   - No (If checked, go to 4) ☐
   - Unknown (If checked, go to 4) ☐
   - ACTION REQUIRED: Submit supporting documentation
4. Has the patient had an improvement in signs and symptoms of the disease since the start of therapy with the requested drug? **Y** ☐ **N** ☐
5. Does the patient have a pretreatment cortisol level as measured by one of the following tests: A) Urinary free cortisol (UFC), B) Late-night salivary cortisol (LNSC), C) 1 mg overnight dexamethasone suppression test (DST), or D) Longer, low dose DST (2 mg per day for 48 hours)? ACTION REQUIRED: If Yes, attach lab report with pretreatment cortisol level.
   - Yes (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation
6. Did the patient have surgery that was not curative? **Y** ☐ **N** ☐
7. Is the patient a candidate for surgery? **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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