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:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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?
   - High-risk neuroblastoma (HRNB) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. How many months has the patient received therapy with the requested drug?
   - 24 months or greater (If checked, no further questions) ☐
   - 23 months (If checked, no further questions) ☐
   - 22 months (If checked, no further questions) ☐
   - 21 months (If checked, no further questions) ☐
   - 20 months (If checked, no further questions) ☐
   - 19 months (If checked, no further questions) ☐
   - 18 months (If checked, no further questions) ☐
   - 17 months (If checked, no further questions) ☐
   - 16 months (If checked, no further questions) ☐
   - 15 months (If checked, no further questions) ☐
   - 14 months (If checked, no further questions) ☐
   - 13 months (If checked, no further questions) ☐
   - 12 months or less (If checked, no further questions) ☐
5. Is the requested drug being used to reduce the risk of relapse? **Y** ☐ **N** ☐

6. Has the patient demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy (e.g. dinutuximab [Unituxin], naxitamab-gqgk [Danyelza])? **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