PA Request Criteria

00-000000000

243133

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:** 10/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **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?
   - Duchenne muscular dystrophy (DMD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____
2. Will the requested medication be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)? **Y** ☐ **N** ☐
3. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing showing a mutation in the DMD gene? ACTION REQUIRED: If Yes, attach a copy of the laboratory report confirming DMD gene mutation. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
4. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by a muscle biopsy demonstrating absent dystrophin? ACTION REQUIRED: If Yes, attach a copy of the patient's medical record confirming a muscle biopsy demonstrated absent dystrophin. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. What is the patient's age (in years)?
   - Less than 2 years of age (If checked, no further questions) ☐
   - 2 years of age or older (If checked, go to 6) ☐
6. Has the patient tried treatment with prednisone or prednisolone? **Y** ☐ **N** ☐
7. Did the patient experience unmanageable and clinically significant weight gain or obesity while receiving treatment with prednisone or prednisolone? ACTION REQUIRED: If Yes, attach chart documentation of weight gain or obesity with prednisone or prednisolone treatment. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
8. What is/was the patient's age at the time of prednisone or prednisolone treatment?
   - 2 years to 19 years of age (If checked, go to 9) ☐
   - 20 years of age or older (If checked, go to 10) ☐
9. What was the body mass index percentile while receiving treatment with prednisone or prednisolone?
   - Less than 85th percentile (If checked, go to 11) ☐

85th percentile or higher (If checked, go to 12) ☐

10. What was the body mass index while receiving treatment with prednisone or prednisolone?

    Less than 25 (If checked, go to 11) ☐

    25 or more (If checked, go to 12) ☐

11. Did the patient experience unmanageable and clinically significant psychiatric or behavioral issues while receiving treatment with prednisone or prednisolone (e.g., abnormal behavior, aggression or irritability)? **Y** ☐ **N** ☐

12. Is this request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

13. Is the patient receiving a clinical benefit from therapy with the requested medication (e.g., improvement or stabilization of muscle strength or pulmonary function)? **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