PA Request Criteria

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185907

Patient Name: _____ **Date:** 5/13/2025
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?
   - Autosomal dominant polycystic kidney disease (ADPKD) ☐
   - Other, please specify. ☐

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

3. Has the patient experienced a beneficial response to the requested drug (e.g., slowed kidney function decline, decreased kidney pain)? **Y** ☐ **N** ☐

4. What is the patient's estimated glomerular filtration rate (eGFR)? Indicate in mL/min/1.73m^2.
   - Greater than or equal to 25 mL/min/1.73m^2 ☐
   - Less than 25 mL/min/1.73m^2 ☐

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

6. Does the patient have a first degree relative with autosomal dominant polycystic kidney disease (ADPKD)? **Y** ☐ **N** ☐

7. What is the patient's age? Indicate age.
   - 18 to less than 40 years old ☐
   - 40 to less than 60 years old ☐
   - 60 years old or older ☐

8. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 3 cysts (unilateral or bilateral) using any radiologic method? ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 2 cysts per kidney using any radiologic method? ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis.
ACTION REQUIRED: Submit supporting documentation

Y ☐ **N** ☐

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.

10. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 4 cysts per kidney using any radiologic method? ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation ☐
11. Does the patient have a mutation in the PKD1 or PKD2 gene as confirmed by a positive genetic test? ACTION REQUIRED: If Yes, please attach laboratory report confirming presence of genetic mutation. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation
12. Does the patient have or is at risk for rapidly progressing disease? **Y** ☐ **N** ☐
13. Does the patient have height-adjusted total kidney volume compatible with Mayo class 1C, 1D, or 1E disease? ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for confirmation of rapidly progressing disease. Yes ☐

    No/unknown

    ACTION REQUIRED: Submit supporting documentation

14. What is the patient's estimated glomerular filtration rate (eGFR)? Indicate in mL/min/1.73m^2.

    Greater than or equal to 25 mL/min/1.73m^2

    Less than 25 mL/min/1.73m^2

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