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 syndrome/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 achieved or maintained an adequate positive response, or is there improvement in signs and symptoms of the condition? **Y** ☐ **N** ☐
4. Did the patient have surgery that was not curative? **Y** ☐ **N** ☐
5. Is the patient a candidate for surgery? **Y** ☐ **N** ☐
6. Does the patient have type 2 diabetes mellitus or glucose intolerance? ACTION REQUIRED: If Yes, attach lab report with pretreatment hemoglobin A1C level. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
7. Is the requested drug being prescribed to control hyperglycemia secondary to hypercortisolism? **Y** ☐ **N** ☐
8. Is the patient able to become pregnant? **Y** ☐ **N** ☐
9. Has the patient been given a recent pregnancy test that was confirmed to be negative? **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.

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Prescriber (Or Authorized) Signature and Date