PA Request Criteria

00-000000000

214724

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 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?
   - Neurofibromatosis type 1 (If checked, go to 2) ☐
   - Circumscribed Glioma (If checked, go to 2) ☐
   - Langerhans cell histiocytosis (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. What is the diagnosis?
   - Neurofibromatosis type 1 (If checked, go to 5) ☐
   - Circumscribed Glioma (If checked, go to 8) ☐
   - Langerhans cell histiocytosis (If checked, go to 11) ☐
5. What is the clinical setting in which the requested medication will be used?
   - Symptomatic, inoperable plexiform neurofibromas (PN) (If checked, go to 6) ☐
   - Recurrent NF-1 mutated glioma (If checked, go to 7) ☐
   - Progressive NF-1 mutated glioma (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
6. Is the patient a pediatric patient at least 2 years of age and older? **Y** ☐ **N** ☐
7. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐
8. What is the clinical setting in which the requested medication will be used?
   - Recurrent disease (If checked, go to 9) ☐

Progressive disease (If checked, go to 9) ☐

Other, please specify. (If checked, no further questions) ☐

_____

9. Does the patient's disease have a BRAF fusion or BRAF V600E activation mutation?
ACTION REQUIRED: Please attach documentation of BRAF fusion or BRAF V600E mutation status.

Yes, BRAF fusion (If checked, go to 10) ☐

Yes, BRAF V600E activation mutation (If checked, go to 10) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

11. Will the requested medication be used as a single agent? **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