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:** 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. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Dupixent, Humira), targeted synthetic drug (e.g., Olumiant, Otezla, Rinvoq, Xeljanz) or potent immunosuppressant such as azathioprine or cyclosporine? **Y** ☐ **N** ☐
2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Cibinqo, Olumiant, Xeljanz) associated with an increased risk of tuberculosis? **Y** ☐ **N** ☐
3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferonrelease assay [IGRA]) within 12 months of initiating therapy? **Y** ☐ **N** ☐
4. What were the results of the tuberculosis (TB) test?
   - Positive for TB (If checked, go to 5) ☐
   - Negative for TB (If checked, go to 6) ☐
   - Unknown (If checked, no further questions) ☐
5. Which of the following applies to the patient?
   - Patient has latent TB and treatment for latent TB has been initiated (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has been completed (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has not been initiated (If checked, no further questions) ☐
   - Patient has active TB (If checked, no further questions) ☐
6. What is the diagnosis?
   - Alopecia areata (If checked, go to 7) ☐
   - Other, please specify (If checked, no further questions) ☐

   _____
7. Has the patient been diagnosed with severe alopecia areata? **Y** ☐ **N** ☐

8. Is the patient 12 years of age or older? Y ☐ N ☐

9. Is the requested drug being prescribed by or in consultation with a dermatologist? Y ☐ N ☐

10. Is this request for continuation of therapy with the requested drug? Y ☐ N ☐

11. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   Yes (If checked, go to 14) ☐
   No (If checked, go to 12) ☐
   Unknown (If checked, go to 14) ☐

12. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug? Y ☐ N ☐

13. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage, 80% total scalp hair coverage [SALT score of 20 or less])? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

14. Has the patient received in the past year or is currently receiving a targeted synthetic drug (e.g., Leqselvi, Olumiant) indicated for the treatment of severe alopecia areata (excluding receiving the drug via samples or a manufacturer's patient assistance program)? Y ☐ N ☐

15. Does the patient have at least 50% scalp hair loss (e.g., Severity of Alopecia Tool [SALT] score of 50 or higher)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting at least 50% scalp hair loss. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

16. Have other forms of alopecia been ruled out (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss, tinea capitis)? Y ☐ N ☐

17. Does the prescribed dose exceed 50 mg? Y ☐ N ☐

18. Does the prescribed frequency exceed one dose once daily? 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