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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:** 5/22/2026
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?
 - Arginase 1 Deficiency (ARG1-D) (If checked, go to 2)
 - Other, please specify. (If checked, no further questions)

2. Will the requested drug be prescribed by or in consultation with a physician who specializes in the treatment of enzyme or metabolic disorders? **Y** **N**
3. Is this a request for continuation of therapy? **Y** **N**
4. Has the patient received a liver or hematopoietic transplant procedure? **Y** **N**
5. Has the patient achieved a pre-dose plasma arginine level between 50 micromol/L and 150 micromol/L? **ACTION REQUIRED:** If Yes, attach lab results documenting pre-dose plasma arginine levels. **ACTION REQUIRED:** Submit supporting documentation **Y** **N**
6. Will the dose of the requested drug be adjusted as outlined in the manufacturer's prescribing information? **Y** **N**
7. Does the requested dose exceed 0.2 mg/kg once weekly? **Y** **N**
8. What is the patient's age?
 - Less than 2 years of age (If checked, no further questions)
 - 2 years to 32 years of age (If checked, go to 9)
 - Greater than 32 years of age (If checked, no further questions)
9. Does the patient have elevated plasma arginine levels (i.e., greater than or equal to 250 micromol/L) prior to initiating therapy with the requested drug? **ACTION REQUIRED:** If Yes, attach lab results documenting elevated plasma arginine levels (i.e., greater than or equal to 250 micromol/L). **ACTION REQUIRED:** Submit supporting documentation **Y** **N**
10. Is the diagnosis confirmed by genetic testing documenting pathogenic variant(s) in the ARG1 gene. **ACTION REQUIRED:** If Yes, attach genetic testing results supporting pathogenic (or likely pathogenic) variant in the ARG1 gene. **ACTION REQUIRED:** Submit supporting documentation **Y** **N**

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| 11. | Is the diagnosis confirmed with an enzyme assay demonstrating a deficiency of arginase enzyme activity (i.e., less than 1% of normal) in erythrocytes? ACTION REQUIRED: If Yes, attach lab results documenting enzyme assay demonstrating a deficiency of arginase enzyme activity (i.e., less than 1% of normal) in erythrocytes.
ACTION REQUIRED: Submit supporting documentation | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 12. | Will the requested drug be used in conjunction with dietary protein restriction? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 13. | Has the patient had an active infection requiring anti-infective therapy within 3 weeks of initiating treatment with the requested drug? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 14. | Does the patient have a known active infection with human immunodeficiency virus (HIV), hepatitis B, or hepatitis C? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 15. | Does the patient have a history of hypersensitivity to polyethylene glycol that, in the opinion of the provider, puts the member at unacceptable risk for adverse events? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 16. | Has the patient received a previous liver or hematopoietic transplant procedure? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 17. | Will baseline and subsequent pre-dose plasma arginine levels be collected and monitored as outlined in the manufacturer's prescribing information? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 18. | Will the dose of the requested drug be adjusted as outlined in the manufacturer's prescribing information if the patient's pre-dose plasma arginine levels fall outside of the therapeutic range (i.e., 50 micromol/L to 150 micromol/L)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 19. | Will the initial and subsequent doses of the requested drug exceed 0.2 mg/kg once weekly? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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

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