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:** 6/13/2025
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 patient's diagnosis?
   - Active lupus nephritis (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. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting disease stability or improvement. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
4. Will the patient be using the requested medication in combination with cyclophosphamide? **Y** ☐ **N** ☐
5. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or was lupus nephritis confirmed on kidney biopsy? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins), or kidney biopsy supporting the diagnosis.
   - Yes (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation
6. Does the patient have clinically active lupus renal disease? **Y** ☐ **N** ☐
7. Is the patient currently receiving background therapy with mycophenolate mofetil (MMF) with corticosteroids? **Y** ☐ **N** ☐
8. What is the patient's eGFR per ml/min/1.73 m^2?
   - eGFR is greater than 45 ml per min per 1.73 m^2 (If checked, go to 9) ☐
     _____

eGFR is less than or equal to 45 ml per min per 1.73 m^2 (If checked, no further questions) ☐

_____

9. Will the patient be using the requested medication in combination with cyclophosphamide? **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