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?

Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome) (If checked, go to 2)	☐
Acquired generalized lipodystrophy (i.e., Lawrence syndrome) (If checked, go to 2)	☐
Partial lipodystrophy (If checked, go to 2)	☐
Human immunodeficiency virus (HIV)-related lipodystrophy (If checked, no further questions)	☐
Generalized obesity not associated with generalized lipodystrophy (If checked, no further questions)	☐
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 experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels)?	**Y**	☐	**N** ☐
4.	Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12 ng/ml)? ACTION REQUIRED: If Yes, attach lab report with pretreatment leptin level. ACTION REQUIRED: Submit supporting documentation	**Y**	☐	**N** ☐
5.	Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)?	**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

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