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:** 3/31/2025
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. Will the requested drug be used in combination with any other biologic or targeted synthetic drug for the same indication? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Atopic dermatitis, moderate-to-severe (If checked, go to 23) ☐
   - Prurigo Nodularis (PN) (If checked, go to 3) ☐
   - Other, please specify (If checked, no further questions) ☐

   _____

3. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist? **Y** ☐ **N** ☐

4. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

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

6. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 9) ☐
   - No (If checked, go to 7) ☐
   - Unknown (If checked, go to 9) ☐

7. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity of prurigo nodularis (e.g., clear or almost clear skin) since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Has the patient achieved or maintained a positive clinical response as evidenced by a reduction in pruritis intensity and improvement in extent and severity of nodular lesions of prurigo nodularis since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Has the patient received or is currently receiving a biologic (e.g., Dupixent) within the past year indicated for the treatment of prurigo nodularis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

10. Does the patient have pruritus lasting at least 6 weeks? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of pruritis symptoms. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

11. Does the patient have history or signs of repeated itch-scratch cycle (e.g., scratching, picking, or rubbing)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of pruritis symptoms. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

12. Does the patient have a minimum of 20 nodular lesions? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting the presence of nodular lesions. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

13. Has the patient had an inadequate response to a medium potency to super-high potency topical corticosteroid? Y ☐ N ☐

14. Is information on the active ingredient, strength, and dosage form of the medium to super-high potency topical corticosteroid the patient had an inadequate treatment response to provided? Indicate drug strength in percentage. ACTION REQUIRED: Please attach chart note(s), medical record documentation, or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy. Y ☐ N ☐
   _____
   ACTION REQUIRED: Submit supporting documentation

15. Has the patient had an inadequate response to a topical calcineurin inhibitor? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting prerequisite therapies, including response to therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

16. Has the patient had an inadequate response to phototherapy (e.g., UVB, PUVA)? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting prerequisite therapies, including response to therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

17. Has the patient had an inadequate response to pharmacologic treatment with methotrexate or cyclosporine? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting prerequisite therapies tried, including response to therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

18. Has the patient had an intolerance or a clinical reason to avoid medium to super-high potency topical corticosteroids? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting intolerance or clinical reason to avoid therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

19. Has the patient had an intolerance or a clinical reason to avoid topical calcineurin inhibitors? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting intolerance or clinical reason to avoid therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

20. Has the patient had an intolerance to pharmacologic treatment with methotrexate and cyclosporine? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. Y ☐ N ☐
   ACTION REQUIRED: Submit supporting documentation

21. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. Y ☐ N ☐

22. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.

   Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, no further questions) ☐

   Drug interaction (If checked, no further questions) ☐

   Risk of treatment-related toxicity (If checked, no further questions) ☐

Pregnancy or currently planning pregnancy (If checked, no further questions) ☐

Breastfeeding (If checked, no further questions) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, no further questions) ☐

Hypersensitivity (If checked, no further questions) ☐

History of intolerance or adverse event (If checked, no further questions) ☐

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

_____

ACTION REQUIRED: Submit supporting documentation

23. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist? **Y** ☐ **N** ☐

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

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

26. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

Yes (If checked, go to 28) ☐

No (If checked, go to 27) ☐

Unknown (If checked, go to 28) ☐

27. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

28. Is the requested medication being prescribed in combination with a low potency to medium potency topical corticosteroid or topical calcineurin inhibitor? **Y** ☐ **N** ☐

29. Is the use of low potency to medium potency topical corticosteroids and topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? **Y** ☐ **N** ☐

30. Has the patient received or is currently receiving a biologic (e.g., Dupixent) or systemic targeted synthetic drug (e.g., Cibinqo, Rinvoq) within the past year indicated for the treatment of moderate-to-severe atopic dermatitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

31. What is the percentage of body surface area (BSA) affected prior to initiation of the requested drug? Please indicate BSA percentage. ACTION REQUIRED: Please attach chart note(s) or medical record documentation of body surface area affected.

Less than 10% of BSA (If checked, go to 32) ☐

_____

Greater than or equal to 10% of BSA (If checked, go to 33) ☐

_____

ACTION REQUIRED: Submit supporting documentation

32. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of affected area(s). **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

33. Has the patient had an inadequate treatment response with a medium potency to super-high potency topical corticosteroid in the past year? **Y** ☐ **N** ☐

34. Is the information on the active ingredient, strength, and dosage form of the medium potency to super-high potency topical steroid the patient had an inadequate treatment response to in the past year provided? ACTION REQUIRED: Please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy.

Yes (If checked, no further questions) ☐

No (If checked, go to 35) ☐

ACTION REQUIRED: Submit supporting documentation

35. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

36. Has the patient had an inadequate treatment response with a topical Janus kinase (JAK) inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

37. Has the patient had an inadequate treatment response with a topical phosphodiesterase-4 (PDE-4) inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

38. Is the use of medium potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

39. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

40. Is the use of topical Janus kinase (JAK) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

41. Is the use of topical phsophodiesterase-4 (PDE-4) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

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.

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Prescriber (Or Authorized) Signature and Date