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 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?
   - Idiopathic pulmonary fibrosis (IPF) (If checked, go to 2) ☐
   - Other chronic fibrosing interstitial lung disease with a progressive phenotype or progressive pulmonary fibrosis (PPF)? (If checked, go to 2) ☐
   - Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐

3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 4) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, go to 4) ☐

4. What is the diagnosis?
   - Idiopathic pulmonary fibrosis (IPF) (If checked, go to 5) ☐
   - Other chronic fibrosing interstitial lung disease with a progressive phenotype or progressive pulmonary fibrosis (PPF) (If checked, go to 13) ☐
   - Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (If checked, go to 15) ☐

5. Have other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) been excluded? **Y** ☐ **N** ☐

6. Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest? ACTION REQUIRED: If Yes, attach the radiology report. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Has the patient undergone a lung biopsy? ACTION REQUIRED: If Yes, attach the pathology report. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Please indicate what the lung biopsy report demonstrates:

Usual interstitial pneumonia (UIP) pattern (If checked, no further questions) ☐

Other, please specify (If checked, go to 12) ☐

_____

9. Please indicate what the high-resolution computed tomography (HRCT) scan demonstrates:

Usual interstitial pneumonia (UIP) pattern (If checked, no further questions) ☐

Other (e.g., probable UIP, indeterminate for UIP, or alternative diagnosis) (If checked, go to 10) ☐

10. Has the diagnosis of idiopathic pulmonary fibrosis been supported by a lung biopsy? ACTION REQUIRED: If Yes, attach the pathology report.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

11. Has the diagnosis of idiopathic pulmonary fibrosis been supported by a multidisciplinary discussion between at least a pulmonologist and a radiologist who are experienced in idiopathic pulmonary fibrosis? **Y** ☐ **N** ☐

12. Does the patient have a chronic fibrosing interstitial lung disease with a progressive phenotype or progressive pulmonary fibrosis (PPF)? **Y** ☐ **N** ☐

13. Did the patient complete a high-resolution computed tomography (HRCT) study of the chest that shows fibrosis affecting at least 10 percent of the patient's lungs? ACTION REQUIRED: If Yes, attach the radiology report.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

14. Does the patient have progressive disease (e.g., forced vital capacity [FVC] decline greater than or equal to 10% of the predicted value, worsening respiratory symptoms, increased extent of fibrosis on high-resolution computed tomography [HRCT])? **Y** ☐ **N** ☐

15. Has the diagnosis been confirmed by a high-resolution computed tomography (HRCT) study of the chest? ACTION REQUIRED: If Yes, attach the radiology report.
ACTION REQUIRED: Submit supporting documentation **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