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:** 10/9/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
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. Will the requested drug be used concomitantly with any other biologic or targeted synthetic drug for the same indication? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Asthma, moderate-to-severe (If checked, go to 3) ☐
   - Chronic spontaneous urticaria (CSU) (If checked, go to 19) ☐
   - Chronic rhinosinusitis with nasal polyps (CRSwNP) (If checked, go to 28) ☐
   - IgE-mediated food allergy (If checked, go to 47) ☐
   - Immune checkpoint inhibitor-related toxicity (If checked, go to 59) ☐
   - Systemic mastocytosis (If checked, go to 64) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Is the requested drug being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? **Y** ☐ **N** ☐

4. Is the patient 6 years of age or older? **Y** ☐ **N** ☐

5. Is the 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 10) ☐
   - No (If checked, go to 7) ☐
   - Unknown (If checked, go to 10) ☐

7. Has the patient's asthma control improved as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Has the patient's asthma control improved as demonstrated by a reduction or discontinuation in the daily maintenance oral corticosteroid dose? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control.
   ACTION REQUIRED: Submit supporting documentation
   Y ☐ **N** ☐

9. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid [ICS] and additional controller) in combination with the requested drug?
   Y ☐ **N** ☐

10. Has the patient received in the past 12 months or is currently receiving a biologic drug (e.g., Nucala, Cinqair) indicated for treatment of asthma (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 including drug, dose, frequency, and duration.
    ACTION REQUIRED: Submit supporting documentation
    Y ☐ **N** ☐

11. Will the requested drug be used for the treatment of moderate-to-severe asthma?
    Y ☐ **N** ☐

12. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past 12 months?
    Y ☐ **N** ☐

13. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s) within the past 12 months?
    Y ☐ **N** ☐

14. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past 12 months?
    Y ☐ **N** ☐

15. Prior to the requested drug, did the patient have inadequate asthma control despite adherence to current treatment with both of the following drugs at optimized doses: A) Medium-to-high-dose inhaled corticosteroid, AND B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried including drug, dose, frequency, and duration.
    ACTION REQUIRED: Submit supporting documentation
    Y ☐ **N** ☐

16. Does the patient have a positive skin test or in vitro reactivity to at least one perennial aeroallergen?
    Y ☐ **N** ☐

17. Prior to starting the requested drug, what was the patient's pre-treatment IgE level (IU/mL)? Please enter pre-treatment IgE level in IU/mL. ACTION REQUIRED: Please attach chart notes or medical record documentation with the patient's pre-treatment IgE level.

    Greater than or equal to 30 IU/mL (If checked, go to 18) ☐

    _____

    Less than 30 IU/mL (If checked, no further questions) ☐

    _____

    Unknown (If checked, no further questions) ☐

    ACTION REQUIRED: Submit supporting documentation

18. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid [ICS] and additional controller) in combination with the requested drug?
    Y ☐ **N** ☐

19. Is the requested drug being prescribed by or in consultation with an allergist, immunologist, or dermatologist?
    Y ☐ **N** ☐

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

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

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

    Yes (If checked, go to 24) ☐

    No (If checked, go to 23) ☐

    Unknown (If checked, go to 24) ☐

23. Has the patient experienced a positive response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

24. Has the patient received in the past 12 months or is currently receiving a biologic drug (e.g., Dupixent) indicated for treatment of chronic spontaneous urticaria (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.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

25. For how long has the patient had a spontaneous onset of wheals (hives), angioedema, or both?

- Less than 6 weeks (If checked, no further questions) ☐
- 6 weeks or longer (If checked, go to 26) ☐

26. Does the patient remain symptomatic despite treatment with up-dosing (in accordance with EAACI/GA2LEN/EuroGuiDerm/APAAACI guidelines) of a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried showing inadequate response to up-dosing of a second-generation H1 antihistamine.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

27. Has the patient been evaluated for other causes of wheals (hives) and/or angioedema, including bradykinin-related angioedema (e.g., angiotensin-converting-enzyme (ACE)-inhibitor induced angioedema, hereditary angioedema) and interleukin-1-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis)? — Y ☐ N ☐

28. Is the requested drug being prescribed by or in consultation with an allergist, immunologist, or otolaryngologist? — Y ☐ N ☐

29. Is the patient 18 years of age or older? — Y ☐ N ☐

30. Is the request for continuation of therapy with the requested drug? — Y ☐ N ☐

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

- Yes (If checked, go to 35) ☐
- No (If checked, go to 32) ☐
- Unknown (If checked, go to 35) ☐

32. Has the patient achieved or maintained a positive clinical response with the requested drug as evidenced by improvement in signs and symptoms (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain, or reduction in corticosteroid use)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

33. Will the patient continue to use a daily intranasal corticosteroid while being treated with the requested drug? — Y ☐ N ☐

34. Are intranasal corticosteroids contraindicated or not tolerated? — Y ☐ N ☐

35. Has the patient received in the past 12 months or is currently receiving a biologic drug (e.g., Dupixent, Nucala) indicated for treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) (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 including drug, dose, frequency, and duration.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

36. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis? — Y ☐ N ☐

37. Has the patient had intranasal corticosteroid treatment for at least 4 weeks? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

38. Are intranasal corticosteroids contraindicated or not tolerated? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

39. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation showing nasal endoscopy, rhinoscopy, or CT details (e.g., polyps location, size).
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

40. Does the patient have a Meltzer Clinical Score of 2 or higher in both nostrils? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of Meltzer Clinical score.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

41. Does the patient have a total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of endoscopic nasal polyps score.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

42. Does the patient have symptoms of nasal blockage, congestion, or obstruction?
Y ☐ N ☐

43. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?
Y ☐ N ☐

44. Prior to starting the requested drug, what was the patient's pre-treatment IgE level (IU/mL)? Please enter pre-treatment IgE level in IU/mL. ACTION REQUIRED: Please attach chart notes or medical record documentation with the patient's pre-treatment IgE level.

- Greater than or equal to 30 IU/mL (If checked, go to 45) ☐
- Less than 30 IU/mL (If checked, no further questions) ☐
- Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

45. Will the patient continue to use a daily intranasal corticosteroid while being treated with the requested drug?
Y ☐ N ☐

46. Are intranasal corticosteroids contraindicated or not tolerated?
Y ☐ N ☐

47. Is the requested drug being prescribed by or in consultation with an allergist or immunologist?
Y ☐ N ☐

48. Is the patient 1 year of age or older?
Y ☐ N ☐

49. Is the request for continuation of therapy with the requested drug?
Y ☐ N ☐

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

- Yes (If checked, go to 53) ☐
- No (If checked, go to 51) ☐
- Unknown (If checked, go to 53) ☐

51. Has the patient achieved or maintained a positive clinical response as evidenced by a reduction or absence of hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal [GI] symptoms) to food-allergen? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

52. Will the patient continue to maintain a food-allergen avoidance diet?
Y ☐ N ☐

53. Has the patient's IgE-mediated food allergy been confirmed by a pretreatment allergen-specific IgE level? ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or laboratory tests showing the patient's pretreatment allergen-specific IgE level.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

54. Has the patient's IgE-mediated food allergy been confirmed by a skin-prick test (SPT)? ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or laboratory tests showing a positive skin-prick test.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

55. Has the patient had a positive physician controlled oral food challenge (e.g., moderate to severe skin, respiratory, or gastrointestinal [GI] symptoms)? ACTION REQUIRED: If Yes, attach chart notes or medical record documentation showing positive result of a physician controlled oral food challenge.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

56. Does the patient have a history of a systemic reaction to a food? ACTION REQUIRED: If yes, please attach chart notes or medical record documentation showing a history of a systemic reaction to a food.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

57. What is the patient's pre-treatment serum IgE level in IU/mL? Indicate pre-treatment serum IgE level in IU/mL. ACTION REQUIRED: Please attach chart notes, medical record documentation, or laboratory tests showing pre-treatment serum IgE level.

Greater than or equal to 30 IU/mL (If checked, go to 58) ☐

_____

Less than 30 IU/mL (If checked, no further questions) ☐

_____

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

58. Will the patient continue to maintain a food-allergen avoidance diet?
Y ☐ N ☐

59. Is the requested drug being prescribed by or in consultation with a dermatologist, hematologist, or oncologist?
Y ☐ N ☐

60. Does the patient have a refractory case of immunotherapy-related moderate (G2) or severe (G3) pruritus?
Y ☐ N ☐

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

62. Did the patient have no response to gabapentinoids in one month?
Y ☐ N ☐

63. Does the patient have elevated IgE levels? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation showing pre-treatment IgE level.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

64. Is the requested drug being prescribe by or in consultation with an allergist, immunologist, dermatologist, hematologist, or oncologist?
Y ☐ N ☐

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

66. 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 since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

67. Does the patient have the major and at least one minor diagnostic criterion for systemic mastocytosis present (see Appendix)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

68. Does the patient have three or more minor diagnostic criteria present for systemic mastocytosis (see Appendix)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis.
ACTION REQUIRED: Submit supporting documentation
Y ☐ N ☐

69. Is the requested drug being prescribed as a step-wise prophylactic treatment for chronic mast cell mediator-related cardiovascular and pulmonary symptoms?
Y ☐ N ☐

70. Has the patient tried both of the following: A) H1 blockers and H2 blockers, and B) Corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical records, or claims history supporting previous medications tried.
ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

71. Is the requested drug being prescribed for prevention of recurrent unprovoked anaphylaxis? — **Y** ☐ **N** ☐

72. Is the requested drug being prescribed for prevention of hymenoptera or food-induced anaphylaxis? — **Y** ☐ **N** ☐

73. Does the patient have negative specific IgE or a negative skin test? — **Y** ☐ **N** ☐

74. Is the requested drug being prescribed to improve tolerance while on venom immunotherapy? — **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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