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:** 8/9/2024
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. Is the requested drug being prescribed in combination with therapeutic biologics, other janus kinase (JAK) inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine? **Y** ☐ **N** ☐
2. Is the request for an adult or pediatric patient 12 years of age or older? **Y** ☐ **N** ☐
3. Is the requested drug being prescribed for the topical treatment of nonsegmental vitiligo? **Y** ☐ **N** ☐
4. Will the requested drug be applied to affected areas of greater than 10 percent body surface area (BSA)? **Y** ☐ **N** ☐
5. Is this request for continuation of therapy? **Y** ☐ **N** ☐
6. Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., meaningful repigmentation)? **Y** ☐ **N** ☐
7. Is the requested drug being prescribed to treat a body surface area (BSA) that requires MORE than 60 grams per 28 days?
   [NOTE: 60 grams of the requested drug would equate to a treatment area of approximately 4 percent BSA.] **Y** ☐ **N** ☐
8. Does the patient require MORE than the plan allowance of 180 grams per 28 days?
   [NOTE: 180 grams of the requested drug per 28 days allows for the maximum FDA approved coverage of 10 percent body surface area (BSA).] **Y** ☐ **N** ☐
9. Is the requested drug being prescribed to treat a body surface area (BSA) that requires MORE than 60 grams per 28 days?
   [NOTE: 60 grams of the requested drug would equate to a treatment area of approximately 4 percent BSA.] **Y** ☐ **N** ☐
10. Does the patient require MORE than the plan allowance of 180 grams per 28 days?
    [NOTE: 180 grams of the requested drug per 28 days allows for the maximum FDA approved coverage of 10 percent body surface area (BSA).] **Y** ☐ **N** ☐
11. Is the requested drug being prescribed for the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient? **Y** ☐ **N** ☐
12. Will the requested drug be applied to affected areas of greater than 20 percent body surface area (BSA)? **Y** ☐ **N** ☐

13. Is this request for continuation of therapy? Y ☐ N ☐

14. Has the patient achieved or maintained a positive clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]? Y ☐ N ☐

15. Is the requested drug being prescribed to treat a body surface area (BSA) that requires MORE than 60 grams per 28 days?
    [NOTE: 60 grams of the requested drug would equate to a treatment area of approximately 4 percent BSA.] Y ☐ N ☐

16. Does the patient require MORE than the plan allowance of 240 grams per 28 days?
    [NOTE: 240 grams of the requested drug per 28 days allows for the maximum FDA approved dosage of 60 grams per week.] Y ☐ N ☐

17. Is the patient's disease not adequately controlled with other topical prescription therapies (e.g., medium or higher potency topical corticosteroids, topical calcineurin inhibitor)? Y ☐ N ☐

18. Are other topical prescription therapies not advisable (e.g., medium or higher potency topical corticosteroid, topical calcineurin inhibitor)? Y ☐ N ☐

19. Is the requested drug being prescribed to treat a body surface area (BSA) that requires MORE than 60 grams per 28 days?
    [NOTE: 60 grams of the requested drug would equate to a treatment area of approximately 4 percent BSA.] Y ☐ N ☐

20. Does the patient require MORE than the plan allowance of 240 grams per 28 days?
    [NOTE: 240 grams of the requested drug per 28 days allows for the maximum FDA approved dosage of 60 grams per week.] 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