PA Request Criteria

00-000000000

231820

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 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?
   - Cystic fibrosis (If checked, go to 2) ☐
   - Other, please specify: (If checked, no further questions) ☐

   _____

2. Will the requested drug be used in combination with another cystic fibrosis transmembrane conductance regulator (CFTR) modulator for the treatment of cystic fibrosis (e.g., Alyftrek, Symdeko)? **Y** ☐ **N** ☐

3. Is the requested drug being prescribed by or in consultation with a pulmonologist? **Y** ☐ **N** ☐

4. Is the patient currently receiving therapy with the requested drug? **Y** ☐ **N** ☐

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

6. Is the patient experiencing benefit from therapy with the requested drug as evidenced by disease stability or disease improvement (e.g., improvement in FEV1 from baseline)? **Y** ☐ **N** ☐

7. Was genetic testing performed to detect a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene?
   - Yes (If checked, go to 8) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

8. Is the patient homozygous for the F508del mutation (positive for the F508del mutation on both alleles) in the CFTR gene? ACTION REQUIRED: If yes, attach genetic testing report.
   - Yes (If checked, go to 9) ☐
   - No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

9. Is the patient 1 year of age or older? **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