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 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?
   - ☐ Primary hypokalemic periodic paralysis (If checked, go to 2)
   - ☐ Primary hyperkalemic periodic paralysis (If checked, go to 2)
   - ☐ Other, please specify. (If checked, no further questions)

   _____

2. Is the request for continuation of therapy? **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 5)
   - ☐ No (If checked, go to 4)
   - ☐ Unknown (If checked, go to 5)

4. Is the patient experiencing a response to therapy as evidenced by an improvement in their condition (e.g., decrease in the number or severity of attacks)? **Y** ☐ **N** ☐

5. What is the diagnosis?
   - ☐ Primary hypokalemic periodic paralysis (If checked, go to 6)
   - ☐ Primary hyperkalemic periodic paralysis (If checked, go to 8)

6. Was the diagnosis confirmed with at least one of the following criteria: A) Genetic testing, B) Family history of primary hypokalemic periodic paralysis, or C) Ruling out the diagnoses of both Andersen-Tawil syndrome and thyrotoxic periodic paralysis?
   - ☐ Yes - Genetic testing (If checked, go to 10)
   - ☐ Yes - Family history of primary hypokalemic periodic paralysis (If checked, go to 10)
   - ☐ Yes - Ruled out diagnoses of Anderson-Tawil syndrome AND thyrotoxic periodic paralysis (If checked, go to 7)
   - ☐ No (If checked, no further questions)

7. Are the patient's attacks associated with hypokalemia? **Y** ☐ **N** ☐

8. Was the diagnosis confirmed with at least one of the following criteria: 1) Genetic testing, 2) Family history of primary hyperkalemic periodic paralysis, or 3) Ruling out the diagnosis of Andersen-Tawil syndrome?

- Yes - Genetic testing (If checked, go to 10) ☐
- Yes - Family history of primary hyperkalemic periodic paralysis (If checked, go to 10) ☐
- Yes - Ruled out diagnosis of Anderson-Tawil syndrome (If checked, go to 9) ☐
- No (If checked, no further questions) ☐

9. Are the patient's attacks associated with hyperkalemia? **Y** ☐ **N** ☐

10. Has the patient tried and had a suboptimal response to treatment with acetazolamide? **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