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:** 1/23/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
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?
   - Acromegaly (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently on therapy with the requested medication? **Y** ☐ **N** ☐

3. How does the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender? ACTION REQUIRED: Attach laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level.
   - IGF-1 level is higher than the laboratory's normal range (If checked, go to 4) ☐
   - IGF-1 level is lower than the laboratory's normal range (If checked, no further questions) ☐
   - IGF-1 level falls within the laboratory's normal range (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

4. Has the patient had an inadequate or partial response to surgery? ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Is there a clinical reason why the patient has not had surgery? ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating a clinical reason for not having surgery. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy? ACTION REQUIRED: If decreased or normalized, attach laboratory report indicating normal current IGF-1 levels or chart note(s) indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.
   - Increased (If checked, no further questions) ☐
   - Decreased or normalized (If checked, no further questions) ☐
   - No change (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

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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