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:** 10/11/2024
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?
   - Phenylketonuria (PKU) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Was the diagnosis confirmed by a blood phenylalanine (Phe) concentration greater than 600 micromol/L or a genetic test? ACTION REQUIRED: If Yes, please attach blood phenylalanine (Phe) concentration test result or genetic test result. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

3. Is the request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

4. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 10) ☐
   - No (If checked, go to 5) ☐
   - Unknown (If checked, go to 10) ☐

5. Has the patient achieved a clinical response as evidenced by a blood phenylalanine (Phe) concentration of less than or equal to 600 micromol/L? **Y** ☐ **N** ☐

6. Will the requested medication be used concomitantly with Kuvan for phenylketonuria? **Y** ☐ **N** ☐

7. Has the patient been titrated to the maximum allowed dose of 60 mg once daily? **Y** ☐ **N** ☐

8. Has the patient received continuous treatment with the requested medication for at least 16 weeks or more at the maximum allowed dose of 60 mg once daily? **Y** ☐ **N** ☐

9. Will the requested medication be used concomitantly with Kuvan for phenylketonuria? **Y** ☐ **N** ☐

10. Prior to initiation of the requested medication, what was the patient's baseline blood phenylalanine (Phe) concentration?
    - Greater than 600 micromol/L (If checked, go to 11) ☐
    - 600 micromol/L or less (If checked, no further questions) ☐

No baseline blood Phe concentration (If checked, no further questions) ☐

11. Will the requested medication be initiated in a patient currently receiving Kuvan for phenylketonuria (PKU)? **Y** ☐ **N** ☐

12. Will Kuvan be discontinued after an appropriate period of overlap? **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