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. Will the requested drug be used for chronic management of a urea cycle disorder (UCD)? **Y** ☐ **N** ☐

2. Will the requested drug be prescribed by or in consultation with a physician who specializes in the treatment of enzyme or metabolic disorders? **Y** ☐ **N** ☐

3. Is this request for continuation of treatment with the requested drug? **Y** ☐ **N** ☐

4. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ACTION REQUIRED: If Yes, attach enzyme assay, biochemical, or genetic testing results supporting diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

5. Does the patient have elevated plasma ammonia levels at baseline? ACTION REQUIRED: If Yes, attach lab results documenting baseline plasma ammonia levels. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. Is the patient experiencing benefit from therapy with the requested drug as evidenced by a reduction in plasma ammonia levels from baseline? ACTION REQUIRED: If Yes, attach lab results documenting a reduction in plasma ammonia levels from baseline. **Y** ☐ **N** ☐
   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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