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?
   - Amyotrophic lateral sclerosis (ALS) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Does the patient have a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) (e.g., medical history and diagnostic testing including, nerve conduction studies, imaging and laboratory values to support the diagnosis)? ACTION REQUIRED: If Yes, attach documentation (e.g., medical history and diagnostic testing including, nerve conduction studies, imaging and laboratory values to support the diagnosis). **Y** ☐ **N** ☐

3. Is the requested drug prescribed by or in consultation with a neurologist, neuromuscular specialist or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS)? **Y** ☐ **N** ☐

4. Is the patient currently receiving treatment 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 8) ☐
   - No (If checked, go to 6) ☐
   - Unknown (If checked, go to 8) ☐

6. Does the patient require invasive ventilation or tracheostomy? **Y** ☐ **N** ☐

7. Has the patient demonstrated a clinical benefit from therapy? ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes) of response to therapy. **Y** ☐ **N** ☐

8. What is the patient's age?
   - 18 years of age or older (If checked, go to 9) ☐
   - Less than 18 years of age (If checked, no further questions) ☐

9. Does the patient have a tracheostomy? **Y** ☐ **N** ☐

10. Does the patient have a documented forced vital capacity (FVC) or slow vital capacity (SVC) greater than 60% of the predicted value for gender, height, and age? ACTION REQUIRED: If Yes, attach documentation (e.g., medical records, chart notes) supporting forced vital capacity (FVC) or slow vital capacity (SVC) greater than 60% of predicted value for gender, height, and age.

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