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:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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?
   - Adenosine deaminase severe combined immune deficiency (ADA-SCID) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____
2. Will the requested medication be prescribed by an or in consultation with an immunologist or a physician who specializes in the treatment of metabolic disease and/or lysosomal storage disorders? **Y** ☐ **N** ☐
3. Was the diagnosis confirmed by increased red blood cell deoxyadenosine triphosphate (dATP) or trough deoxyadenosine nucleotide (dAXP) concentrations? ACTION REQUIRED: If Yes, attach genetic or molecular test results or medical records confirming the diagnosis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
4. Does the patient have absent or very low (<1% of normal) adenosine deaminase (ADA) activity in red blood cells? ACTION REQUIRED: If Yes, attach genetic or molecular test results or medical records confirming the diagnosis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
5. Was the diagnosis genetically confirmed by biallelic variant in the ADA gene? ACTION REQUIRED: If Yes, attach genetic or molecular test results or medical records confirming the diagnosis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
6. Have baseline values for plasma ADA activity, red blood cell dATP, dAXP levels, and/or total lymphocyte counts been obtained? ACTION REQUIRED: If Yes, attach baseline values for plasma adenosine deaminase (ADA) activity, red blood cell deoxyadenosine triphosphate (dATP), trough deoxyadenosine nucleotide (dAXP) levels, and/or total lymphocyte counts.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
7. Will the requested medication only be used until definitive therapy with hematopoietic stem cell transplantation (HSCT)? **Y** ☐ **N** ☐
8. Has the patient failed HSCT? **Y** ☐ **N** ☐
9. Is the patient a suitable candidate for HSCT (e.g., matched sibling or family donor available)? **Y** ☐ **N** ☐
10. Does the patient have severe thrombocytopenia (platelets less than 50,000/microL)? ACTION REQUIRED: If No, attach hematologic assessment (e.g., complete blood count) demonstrating absence of severe thrombocytopenia (platelets less than 50,000/microL). **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

11.	Does the patient have an autoimmune disease requiring immunosuppressive therapy?	**Y** ☐	**N** ☐
12.	Will the patient be monitored for evidence of treatment efficacy per protocol outlined in the prescribing information during treatment with the requested drug?	**Y** ☐	**N** ☐
13.	Is this request for continuation of treatment with the requested drug?	**Y** ☐	**N** ☐
14.	Does the member have unacceptable toxicity (e.g., severe injection site reactions/bleeding, severe thrombocytopenia)?	**Y** ☐	**N** ☐
15.	Is the patient experiencing benefit from therapy (e.g., maintenance of target trough plasma ADA activity greater than 30 mmol/L, trough erythrocyte dAXP levels below 0.02 mmol/L, improved or stabilized total lymphocyte counts and/or immune function)? ACTION REQUIRED: If Yes, please attach chart notes, lab values, or medical record documentation supporting positive clinical response. ACTION REQUIRED: Submit supporting documentation	**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