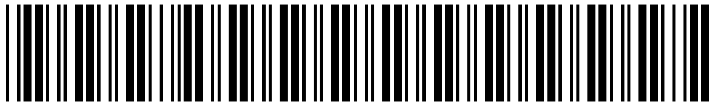
PA Request Criteria



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:** 4/21/2026
Patient ID: ____________________ **Patient Date Of Birth:** ____________________
Patient Group No: ____________________ **NPI#:** **Patient Phone:** ____________________
Physician Name:
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: ____
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Please check the appropriate answer for each applicable question.

1. Is the requested drug being prescribed for the treatment of chronic spontaneous urticaria (CSU) in an adult patient? **Y** ☐ **N** ☐

2. Is the requested drug being prescribed by or in consultation with an allergist, immunologist or dermatologist? **Y** ☐ **N** ☐

3. Will the requested drug be used in combination with any other biologic or targeted synthetic drug for the same indication? **Y** ☐ **N** ☐

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

5. Has the patient experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes or medical record documentation supporting a positive response to therapy. **Y** ☐ **N** ☐
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6. Have chart notes or medical record documentation showing a positive response to therapy been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
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7. Does the patient require MORE than the plan allowance of 60 tablets per month? **Y** ☐ **N** ☐

8. Has the patient previously received a biologic drug (e.g., Xolair, Dupixent) indicated for chronic spontaneous urticaria (CSU) in the past year? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes, medical record documentation, or claims history supporting previous medications tried. **Y** ☐ **N** ☐
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9. Have chart notes, medical record documentation or claims history showing the patient received a biologic drug (e.g., Xolair, Dupixent) indicated for the treatment of chronic spontaneous urticaria (CSU) in the past year been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
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10. Has the patient experienced a spontaneous onset of wheals (hives), angioedema, or both for at least 6 weeks? **Y** ☐ **N** ☐

11. Has the patient been evaluated for other causes of wheals (hives) and/or angioedema, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis). **Y** ☐ **N** ☐

12. Does the patient remain symptomatic despite treatment with up-dosing (in accordance with EAACI/GA2LEN/EuroGuiDerm/APAAACI guidelines) of a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes, medical record documentation, or claims history supporting previous medications tried and inadequate response to up-dosing of a second generation H1 antihistamine. **Y** ☐ **N** ☐

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13. Have chart notes, medical record documentation or claims history showing that the patient remains symptomatic despite treatment with up-dosing of a second-generation H1 antihistamine for at least 2 weeks been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

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14. Does the patient require MORE than the plan allowance of 60 tablets per month? **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.

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Prescriber (Or Authorized) Signature and Date

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