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:** 5/29/2025

Patient ID: _____ **Patient Date Of Birth:** _____

Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____

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?

   Primary hyperoxaluria type (PH1) (If checked, go to 2) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

2. Does the patient have a documented diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by either of the following? ACTION REQUIRED: If Yes, attach supporting chart note(s) for molecular genetic tests demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis results demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. a) Molecular genetic test demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene, b) Liver enzyme analysis results demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity.
   ACTION REQUIRED: Submit supporting documentation
   Y ☐ **N** ☐

3. Does the patient have a relatively preserved kidney function (e.g., eGFR of greater than or equal to 30 mL/min/1.73 m2)?
   Y ☐ **N** ☐

4. Is the patient 2 years of age or older?
   Y ☐ **N** ☐

5. Will the requested drug be used in combination with lumasiran?
   Y ☐ **N** ☐

6. Is the patient currently receiving treatment with the requested drug?
   Y ☐ **N** ☐

7. Does the patient demonstrate a positive response to therapy (e.g., decrease or normalization in urinary and/or plasma oxalate levels, improvement in kidney function)? ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical records demonstrating a positive response to therapy.

   Yes (If checked, no further questions) ☐

   No (If checked, no further questions) ☐

   Unknown (If checked, no further questions) ☐

   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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