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:** 9/9/2024
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?
   - Friedreich's ataxia (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by or in consultation with a physician who specializes in the treatment of Friedreich's ataxia or a neurologist? **Y** ☐ **N** ☐

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

4. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement (e.g., improvement in speech or swallowing, upper/lower limb coordination, upright stability)? **Y** ☐ **N** ☐

5. Was the patient's diagnosis confirmed by detection of a mutation of the FXN gene? ACTION REQUIRED: If Yes, please attach testing or analysis confirming a mutation of the FXN gene.
   - Yes (If checked, go to 6) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

6. Does the patient exhibit clinical manifestations of disease (e.g., muscle weakness, decline in coordination, frequent falling)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation confirming the patient demonstrates clinical manifestations of disease. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

7. Is the patient 16 years of age or older? **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