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:** 5/13/2025
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?
   - Primary immunoglobulin A nephropathy (IgAN) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____
2. Has the diagnosis of primary immunoglobulin A nephropathy (IgAN) been confirmed by a kidney biopsy? ACTION REQUIRED: If Yes, please attach supporting biopsy report confirming diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
3. Does the patient have proteinuria greater than or equal to 1 g/day based on a 24-hour urine collection? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
4. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 g/g based on a 24-hour urine collection? ACTION REQUIRED: If Yes, please attach supporting laboratory report or chart note(s). **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Has the patient received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitors [ACEIs] or angiotensin II receptor blockers [ARBs]) for at least 3 months of therapy? **Y** ☐ **N** ☐
6. Does the patient have an intolerance or contraindication to RAS inhibitors? **Y** ☐ **N** ☐
7. Has the patient experienced an intolerance to at least one other oral glucocorticoid (e.g., prednisone)? **Y** ☐ **N** ☐
8. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
9. How many months of Tarpeyo has the patient received? Indicate in months.
   - 10 months or longer (If checked, no further questions) ☐
   - Less than 10 months: Please specify in months. (If checked, no further questions) ☐
     _____

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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