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:** 10/13/2025
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 patient's diagnosis?
   - Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse) (If checked, go to 2) ☐
   - Clinically isolated syndrome of multiple sclerosis (If checked, go to 2) ☐
   - Primary progressive multiple sclerosis (If checked, no further questions) ☐
   - Other, please specify (If checked, no further questions) ☐

   _____

2. Will the patient be taking the requested drug with any other disease modifying multiple sclerosis (MS) agent? (Note: Ampyra and Nuedexta are not disease modifying.) **Y** ☐ **N** ☐
3. Will the requested drug be prescribed by or in consultation with a neurologist? **Y** ☐ **N** ☐
4. Is this a request for continuation of therapy? **Y** ☐ **N** ☐
5. Is the patient experiencing disease stability or improvement while receiving the requested drug? **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

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