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:** 6/13/2025
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?
   - Multiple myeloma (If checked, go to 2) ☐
   - Erythema nodosum leprosum (If checked, go to 4) ☐
   - Crohn's disease (If checked, go to 4) ☐
   - Kaposi sarcoma (If checked, go to 2) ☐
   - Chronic graft-versus-host disease (If checked, go to 4) ☐
   - Multicentric Castleman disease (If checked, go to 2) ☐
   - Aphthous stomatitis (If checked, go to 4) ☐
   - Histiocytic neoplasms (If checked, go to 2) ☐
   - Pediatric medulloblastoma (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
3. Is there evidence of disease progression or unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
5. Does the patient have an improvement in symptoms and no unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
6. What is the patient's diagnosis?
   - Multiple myeloma (If checked, no further questions) ☐
   - Erythema nodosum leprosum (If checked, no further questions) ☐
   - Crohn's disease (If checked, no further questions) ☐
   - Kaposi sarcoma (If checked, go to 7) ☐
   - Chronic graft-versus-host disease (If checked, no further questions) ☐

Multicentric Castleman Disease (If checked, no further questions) ☐

Histiocytic neoplasms (If checked, go to 8) ☐

Aphthous Stomatitis (If checked, go to 10) ☐

Pediatric medulloblastoma (If checked, go to 11) ☐

7. What is the place in therapy in which the requested drug will be used?

First-line treatment (If checked, no further questions) ☐

Subsequent treatment (If checked, no further questions) ☐

8. Will the requested drug be used to treat Langerhans cell histiocytosis or Rosai-Dorfman disease? **Y** ☐ **N** ☐

9. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐

10. What is the clinical setting in which the requested drug will be used?

AIDS-related aphthous stomatitis (If checked, no further questions) ☐

Recurrent disease in immunocompromised patients (If checked, no further questions) ☐

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

_____

11. What is the clinical setting in which the requested drug will be used?

Recurrent disease (If checked, go to 12) ☐

Progressive disease (If checked, go to 12) ☐

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

_____

12. Will the requested drug be used as part of MEMMAT (thalidomide, celecoxib, fenofibrate, etoposide, cyclophosphamide, bevacizumab) regimen? **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