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 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?
   - Tenosynovial giant cell tumor (TGCT) (If checked, go to 2) ☐
   - Pigmented villonodular synovitis (PVNS) (If checked, go to 2) ☐
   - Histiocytic neoplasms (If checked, go to 5) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. Will the requested drug be used as a single agent? **Y** ☐ **N** ☐
5. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
6. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
7. Does the patient have any of the following subtypes?
   - Erdheim-Chester disease (ECD) (If checked, go to 8) ☐
   - Rosai-Dorfman disease (RDD) (If checked, go to 8) ☐
   - Langerhans cell histiocytosis (LCH) (If checked, go to 9) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
8. Is the disease symptomatic or relapsed/refractory?
   - Symptomatic disease (If checked, go to 9) ☐
   - Relapsed/ refractory disease (If checked, go to 9) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

10. Does the patient have a colony stimulating factor 1 receptor (CSF1R) mutation? ACTION REQUIRED: Attach supporting chart notes or lab results.

- 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