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. Will the requested drug be used in combination with any other immunomodulator, biologic drug (e.g., Humira), or targeted synthetic drug (e.g., Rinvoq, Xeljanz)? **Y** ☐ **N** ☐
2. What is the diagnosis?
   - Ulcerative colitis (If checked, go to 3) ☐
   - Other, please specify: (If checked, no further questions) ☐
     _____
3. Has the patient been diagnosed with moderately to severely active ulcerative colitis? **Y** ☐ **N** ☐
4. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐
5. Is the requested drug being prescribed by or in consultation with a gastroenterologist? **Y** ☐ **N** ☐
6. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
7. Has the patient achieved or maintained remission? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
8. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? **Y** ☐ **N** ☐
9. Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
   - Stool frequency (If checked, go to 10) ☐
   - Rectal bleeding (If checked, go to 10) ☐
   - Urgency of defecation (If checked, go to 10) ☐

C-reactive protein (CRP) (If checked, go to 10) ☐

Fecal calprotectin (FC) (If checked, go to 10) ☐ ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 10)

Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) (If checked, go to 10) ☐

None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. Does the prescribed dose exceed 2 mg? **Y** ☐ **N** ☐

11. Is the prescribed frequency more frequent than one dose daily? **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