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: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**

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?
   - PIK3CA-Related Overgrowth Spectrum (PROS) (If checked, go to 2) ☐
   - 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. What is the patient's age?
   - Less than 2 years of age (If checked, no further questions) ☐
   - 2 years of age or older (If checked, go to 5) ☐

5. Does the patient have severe manifestations of disease? **Y** ☐ **N** ☐

6. Does the patient require systemic therapy? **Y** ☐ **N** ☐

7. Does the patient have a PIK3CA mutation? ACTION REQUIRED: If Yes, please attach chart note(s) or test results confirming presence of PIK3CA gene mutation.
   - 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

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