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:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_
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?
   - Paroxysmal nocturnal hemoglobinuria (PNH) (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 unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. Did the patient demonstrate a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Will the requested medication be used concomitantly with ravulizumab or eculizumab? **Y** ☐ **N** ☐
6. Will the requested medication be used for the treatment of extravascular hemolysis (EVH)? **Y** ☐ **N** ☐
7. Was the diagnosis of PNH confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs)? **Y** ☐ **N** ☐
8. How was the diagnosis established?
   - Quantification of PNH cells (If checked, go to 9) ☐
   - Quantification of GPI-anchored protein deficient poly-morphonuclear cells (If checked, go to 10) ☐
   - None of the above (If checked, no further questions) ☐
9. What was the percentage of PNH cells?
   - Less than 5% (If checked, no further questions) ☐
   - Greater than or equal to 5% (If checked, go to 11) ☐
10. What was the percentage of GPI-anchored protein deficient poly-morphonuclear cells?
    - Less than 51% (If checked, no further questions) ☐

Greater than or equal to 51% (If checked, go to 11) ☐

11. Was flow cytometry used to demonstrate the deficiency of GPI-anchored proteins? ACTION REQUIRED: If Yes, please attach flow cytometry used to show results of glycosylphosphatidylinositol-anchored proteins (GPI-APs) deficiency. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

12. Does the patient have clinically significant extravascular hemolysis while on ravulizumab or eculizumab? ACTION REQUIRED: If Yes, please attach hemoglobin and absolute reticulocyte count demonstrating clinically significant extravascular hemolysis. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

13. What is the hemoglobin level?

Less than or equal to 9.5 g/dL (If checked, go to 14) ☐

Greater than 9.5 g/dL (If checked, no further questions) ☐

14. What is the absolute reticulocyte count?

Less than 120 x 10^9/L (If checked, no further questions) ☐

Greater than or equal to 120 x 10^9/L (If checked, go to 15) ☐

15. Will the requested medication be used concomitantly with ravulizumab or eculizumab? **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