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:** 4/20/2026
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 diagnosis?
   - Advanced Parkinson's disease (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the requested drug prescribed by or in consultation with a neurologist or a specialist in the treatment of Parkinson's disease? **Y** ☐ **N** ☐
3. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
4. Has the patient demonstrated a positive clinical response with the requested drug? **Y** ☐ **N** ☐
5. Will the requested drug be used for treatment of motor fluctuations in a patient with advanced Parkinson's disease? **Y** ☐ **N** ☐
6. Is the patient levodopa responsive with clearly defined "on" periods? **Y** ☐ **N** ☐
7. Does the patient have "off" periods of at least 2.5 hours per day despite optimization efforts? **Y** ☐ **N** ☐
8. Has the patient had an inadequate response or intolerable adverse event with oral carbidopa/levodopa and one of the following anti-Parkinson agents: A) Dopamine agonist (e.g., pramipexole, ropinirole), B) Monoamine oxidase-B (MAO-B) inhibitor (e.g., selegiline, rasagiline), or C) Catechol-O-methyltransferase (COMT) inhibitor (e.g., entacapone, tolcapone)? ACTION REQUIRED: If yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
   - Yes - Dopamine agonist (If checked, no further questions) ☐
   - Yes - MAO-B inhibitor (If checked, no further questions) ☐
   - Yes - COMT inhibitor (If checked, no further questions) ☐
   - No - None of the above (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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