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:** 7/2/2026
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 diagnosis?
   - Hyperphagia with Prader-Willi syndrome (If checked, go to 2) ☐
   - Other, please specify (If checked, no further questions) ☐

   _____

2.	Is the requested drug prescribed by or in consultation with an endocrinologist, geneticist, or a prescriber specializing in Prader-Willi syndrome?	**Y** ☐	**N** ☐
3.	Is the requested drug for the treatment of hyperinsulinemic hypoglycemia?	**Y** ☐	**N** ☐
4.	Does the patient have a known hypersensitivity to diazoxide or thiazides?	**Y** ☐	**N** ☐
5.	Is the patient currently receiving therapy with the requested drug?	**Y** ☐	**N** ☐
6.	Has the patient achieved or maintained a positive clinical response to treatment (e.g., reduction in hyperphagia, reduction in body fat mass, reduced levels of leptin)? ACTION REQUIRED: If yes, attach chart notes or medical record documentation confirming the member demonstrates a beneficial response to treatment. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
7.	Was the diagnosis of Prader-Willi syndrome confirmed by genetic testing demonstrating any of the following: A) Deletion in the chromosomal 15q11-q13 region, B) Maternal uniparental disomy in chromosome 15, or C) Imprinting defects, translocations, or inversions involving chromosome 15? ACTION REQUIRED: If yes, attach laboratory test result. ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
8.	Does the member have hyperphasia (e.g., food obsession, aggressive food seeking behavior, lack of satiety)?	**Y** ☐	**N** ☐
9.	Has the patient been assessed for hyperglycemia?	**Y** ☐	**N** ☐
10.	Does the patient have clinically significant renal or hepatic impairment?	**Y** ☐	**N** ☐
11.	Is the patient 4 years of age or older?	**Y** ☐	**N** ☐
12.	Does the patient weigh greater than or equal to 20 kilograms (kg)?	**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

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