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:** 9/9/2024
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?
   - Carcinoid syndrome diarrhea (If checked, go to 2) ☐
   - Other, please specify: (If checked, no further questions) ☐

   _____

2. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐
3. Is the request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐
4. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., reduction in the number of daily bowel movements) since starting treatment with the requested medication? **Y** ☐ **N** ☐
5. Is the patient receiving the requested medication in combination with somatostatin analog therapy (e.g., octreotide, lanreotide)? **Y** ☐ **N** ☐
6. Has the patient had an inadequate response to somatostatin analog therapy (e.g., octreotide, lanreotide) alone? **Y** ☐ **N** ☐
7. Will the requested medication be used in combination with somatostatin analog therapy (e.g., octreotide, lanreotide)? **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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