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: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
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?
   - ☐ WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) (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 immunologist, pediatrician, hematologist, or dermatologist? **Y** ☐ **N** ☐
3. Is the patient currently receiving treatment with the requested drug? **Y** ☐ **N** ☐
4. Is the patient experiencing benefit from therapy (e.g., improvement in absolute neutrophil count [ANC], improvement in absolute lymphocyte count [ALC], reduction in infections)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of benefit from therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Does the patient have a genotype-confirmed variant of the CXCR4 gene consistent with WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis)? ACTION REQUIRED: If Yes, please attach genetic testing results confirming a diagnosis of WHIM syndrome. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
6. Does the patient have a confirmed low neutrophil count based on the reference laboratory range or current practice guidelines? ACTION REQUIRED: If Yes, please attach laboratory results of neutrophil count. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
7. Does the patient exhibit at least one of the following clinical manifestations of disease: A) warts, B) hypogammaglobulinemia, C) infections, D) myelokathexis, E) lymphopenia, or F) monocytopenia? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of at least one clinical manifestation of disease.
   - ☐ Yes, please specify - warts, hypogammaglobulinemia, infections, myelokathexis, lymphopenia, and/or monocytopenia (If checked, go to 8)
     _____
   - ☐ No (If checked, no further questions)

   ACTION REQUIRED: Submit supporting documentation
8. Is the patient 12 years of age or older? **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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