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:** 10/11/2024
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?
   - Hypoparathyroidism (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____

2. Does the patient have acute postsurgical hypoparathyroidism (within 6 months of surgery) and is expected to recover from hypoparathyroidism? **Y** ☐ **N** ☐

3. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

4. Is the request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

5. Is the patient experiencing benefit from therapy with the requested drug as evidenced by maintenance or normalization of calcium levels compared to baseline? ACTION REQUIRED: If Yes, please attach laboratory results showing maintenance or normalization of calcium levels compared to baseline. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

6. How long has the patient had hypoparathyroidism?
   - 6 months or more (If checked, go to 7) ☐
   - Less than 6 months (If checked, no further questions) ☐

7. Is the patient receiving vitamin D metabolite/analog therapy with calcitriol greater than or equal to 0.5 mcg per day or alfacalcidol greater than or equal to 1.0 mcg per day? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting current use of vitamin D metabolite/analog. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

8. Is the patient receiving elemental calcium treatment greater than or equal to 800 mg per day? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting current use of elemental calcium. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Is the patient's serum 25-hydroxyvitamin D concentration above the lower limit of normal laboratory range? ACTION REQUIRED: If Yes, please attach lab results showing serum 25-hydroxyvitamin D concentration above the lower limit of normal laboratory range. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

10. Is the patient's albumin-corrected serum calcium level greater than or equal to 7.8 mg/dL prior to initiation of therapy with the requested drug? ACTION REQUIRED: If Yes, please attach lab results showing albumin-corrected serum calcium is greater than or equal to 7.8 mg/dL.
    ACTION REQUIRED: Submit supporting documentation
    Y ☐ **N** ☐

11. Is the patient's serum magnesium level within normal laboratory limits? ACTION REQUIRED: If Yes, please attach lab results showing magnesium level within normal laboratory limits.
    ACTION REQUIRED: Submit supporting documentation
    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