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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:** 5/22/2026  
**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?
  - Achondroplasia (If checked, go to 2)
  - Other, please specify. (If checked, no further questions)
  - \_\_\_\_\_
  
2. Is Yuviwel being prescribed by, or in consultation with, an endocrinologist, pediatric endocrinologist, geneticist, or neurologist?      Y       N
  
3. Has the diagnosis of achondroplasia been confirmed by symptoms (i.e., short stature with marked shortening of extremities due to rhizomelia, a characteristic facial configuration, trident hand) AND X-ray findings consistent with achondroplasia? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of symptoms and laboratory report of X-ray findings AND most recent growth chart, chart notes, or medical record documentation showing heights and growth velocities.  
 ACTION REQUIRED: Submit supporting documentation      Y       N
  
4. Was the diagnosis of achondroplasia confirmed by genetic testing for the FGFR3 variant? ACTION REQUIRED: If Yes, please attach laboratory report of genetic testing AND most recent growth chart, chart notes, or medical record documentation showing heights and growth velocities.  
 ACTION REQUIRED: Submit supporting documentation      Y       N
  
5. Are the epiphyses open?      Y       N
  
6. What is the patient's age?
  - 2 years old or older (If checked, go to 7)
  - Less than 2 years old (If checked, no further questions)
  
7. Is the patient currently receiving Yuviwel?      Y       N
  
8. Has the patient experienced benefit from therapy (e.g., improvement or stabilization of annualized growth velocity [centimeters per year] from baseline)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation confirming benefit from therapy.  
 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.

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**Prescriber (Or Authorized) Signature and Date**

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