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:** 5/13/2025
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. Will the requested drug be used in combination with any other immunomodulator, biologic drug (e.g., Humira), targeted synthetic drug (e.g., Rinvoq, Xeljanz), or disease modifying multiple sclerosis (MS) agent for the same indication? (Note: Ampyra and Nuedexta are not disease modifying). **Y** ☐ **N** ☐
2. What is the diagnosis?
   - Relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse) ☐
   - Clinically isolated syndrome of multiple sclerosis ☐
   - Primary progressive multiple sclerosis (PPMS) ☐
   - Ulcerative colitis ☐
   - Other, please specify. ☐

   _____
3. Is the requested medication prescribed by or in consultation with a neurologist? **Y** ☐ **N** ☐
4. What is the patient's age?
   - Less than 18 years of age ☐
   - 18 years of age or older ☐
5. Has the prescriber evaluated the risks and benefits of treatment and attests the benefits outweigh the risks? **Y** ☐ **N** ☐
6. Is this request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐
7. Is the patient experiencing disease stability or improvement while receiving the requested medication? **Y** ☐ **N** ☐
8. Has the patient been diagnosed with moderately to severely active ulcerative colitis? **Y** ☐ **N** ☐

9.	Is the patient an adult (18 years of age or older)?	Y ☐	N ☐
10.	Is the requested drug prescribed by or in consultation with a gastroenterologist?	Y ☐	N ☐
11.	Is this request for continuation of therapy with the requested medication?	Y ☐	N ☐
12.	Has the patient achieved or maintained remission? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.	Y ☐	N ☐
13.	Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested medication?	Y ☐	N ☐
14.	Which of the following has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.		
	Stool frequency	☐	
	Rectal bleeding	☐	
	Urgency of defecation	☐	
	C-reactive protein (CRP)	☐	
	Fecal calprotectin (FC)	☐	
	Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound	☐	
	Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score)	☐	
	None of the above	☐	
15.	Is the prescribed frequency more frequent than one dose daily?	Y ☐	N ☐
16.	Is the patient currently receiving the requested drug?	Y ☐	N ☐
17.	Does the prescribed dose exceed 0.92 mg?	Y ☐	N ☐
18.	Does the prescribed dose exceed 0.23 mg on days 1 to 4, 0.46 mg on days 5 to 7, and 0.92 mg thereafter?	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