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: _____ **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?
   - Hutchinson-Gilford Progeria Syndrome (If checked, go to 2) ☐
   - Processing Deficient Progeroid Laminopathy with Progerin-Like Protein Accumulation (If checked, go to 7) ☐
   - Processing Deficient Progeroid Laminopathy without Progerin-Like Protein Accumulation (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____

2. Has the diagnosis of Hutchinson-Gilford Progeria Syndrome been confirmed with genetic testing indicating the patient has a LMNA mutation? ACTION REQUIRED: If Yes, attach genetic testing results.
   - Yes (If checked, go to 3) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐
   - ACTION REQUIRED: Submit supporting documentation

3. What is the patient's age?
   - Less than 12 months of age (If checked, no further questions) ☐
   - Greater than or equal to 12 months of age (If checked, go to 4) ☐

4. What is the patient's body surface area (BSA) in meters squared?
   - Less than 0.39 meters squared (If checked, no further questions) ☐
   - Greater than or equal to 0.39 meters squared (If checked, go to 5) ☐

5. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

6. Has the patient experienced a benefit from therapy? **Y** ☐ **N** ☐

7. Has the diagnosis of Processing Deficient Progeroid Laminopathy with Progerin-Like Protein Accumulation been confirmed with genetic testing indicating the patient has a heterozygous LMNA mutation? ACTION REQUIRED: If Yes, attach genetic testing results.

Yes (If checked, go to 8) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

8. What is the patient's age?

Less than 12 months of age (If checked, no further questions) ☐

Greater than or equal to 12 months of age (If checked, go to 9) ☐

9. What is the patient's body surface area (BSA) in meters squared?

Less than 0.39 meters squared (If checked, no further questions) ☐

Greater than or equal to 0.39 meters squared (If checked, go to 10) ☐

10. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

11. Has the patient experienced a benefit from therapy? **Y** ☐ **N** ☐

12. Has the diagnosis of Processing Deficient Progeroid Laminopathy without Progerin-Like Protein Accumulation been confirmed with genetic testing indicating the patient has a homozygous or compound heterozygous ZMPSTE24 mutation? ACTION REQUIRED: If Yes, attach genetic testing results.

Yes (If checked, go to 13) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

13. What is the patient's age?

Less than 12 months of age (If checked, no further questions) ☐

Greater than or equal to 12 months of age (If checked, go to 14) ☐

14. What is the patient's body surface area (BSA) in meters squared?

Less than 0.39 meters squared (If checked, no further questions) ☐

Greater than or equal to 0.39 meters squared (If checked, go to 15) ☐

15. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

16. Has the patient experienced a benefit from therapy? **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