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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:** 3/16/2026  
**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?
  - Menkes disease (If checked, go to 2)
  - Other, please specify (If checked, no further questions)
2. Does the patient have a diagnosis of Occipital Horn Syndrome (OHS)? Y  N
3. Is the requested drug prescribed by or in consultation with a gastroenterologist, neurologist, geneticist, or specialist in the treatment of Menkes disease? Y  N
4. Is the request for continuation of therapy? Y  N
5. Does the patient have evidence of unacceptable toxicity? Y  N
6. What is the patient's age?
  - Less than 17 years of age (If checked, go to 7)
  - 17 years of age or older (If checked, no further questions)
7. Is the patient's disease confirmed by molecular genetic testing showing a variant in the ATP7A gene? ACTION REQUIRED: If yes, attach chart notes, medical record documentation, or molecular genetic test results confirming a variant in the ATP7A gene. ACTION REQUIRED: Submit supporting documentation Y  N
8. Does the patient have a pretreatment serum copper level less than 75 micrograms per deciliter (mcg/dL)? ACTION REQUIRED: If yes, attach pretreatment serum copper level. ACTION REQUIRED: Submit supporting documentation Y  N
9. Will the serum copper level, serum ceruloplasmin level, liver function, kidney function, serum electrolytes, and complete blood count (CBC) be assessed at baseline and will they be monitored after Zycubo administration as clinically appropriate? 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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