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:** 7/17/2024
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 diagnosis?
   - Homocystinuria (If checked, go to 2) ☐
   - Methylmalonic acidemia with homocystinuria (If checked, go to 12) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is this a request for continuation of therapy? **Y** ☐ **N** ☐
3. Is the total homocysteine level undetectable or present only in small amounts? **Y** ☐ **N** ☐
4. Is there a substantial decrease in homocysteine levels? **Y** ☐ **N** ☐
5. Will the dose be increased until maximum tolerability or plasma total homocysteine level is undetectable or present in only small amounts? **Y** ☐ **N** ☐
6. Does the patient have cystathionine beta-synthase (CBS) deficiency? **Y** ☐ **N** ☐
7. Will plasma methionine concentrations be monitored and kept below 1,000 micromol/L through dietary modification, and if necessary, a reduction in dose for the requested drug? **Y** ☐ **N** ☐
8. Will the requested drug be used to decrease elevated homocysteine blood levels? **Y** ☐ **N** ☐
9. Does the patient have one of the following types of homocystinuria?
   - Yes, Cystathionine beta-synthase (CBS) deficiency (If checked, go to 10) ☐
   - Yes, 5,10-methylenetetrahydrofolate reductase (MTHFR) deficiency (If checked, go to 11) ☐
   - Yes, Cobalamin cofactor metabolism (cbl) defect (If checked, go to 11) ☐
   - No, Other, please specify. (If checked, no further questions) ☐

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10. Will plasma methionine concentrations be monitored and kept below 1,000 micromol/L through dietary modification, and if necessary, a reduction in dose for the requested drug? **Y** ☐ **N** ☐

11. Was the diagnosis confirmed by enzyme assay or genetic testing? ACTION REQUIRED: If Yes, please attach supporting documentation for the following: a) For cystathionine beta-synthase (CBS) deficiency, enzyme analysis of CBS activity or genetic testing results, b) For 5,10-methylenetetrahydrofolate reductase (MTHFR) deficiency, enzyme analysis of MTHFR activity or genetic testing results, or c) For cobalamin cofactor metabolism (cbl) defect, genetic testing results.
    ACTION REQUIRED: Submit supporting documentation
    Y ☐ **N** ☐

12. Is this a request for continuation of therapy?
    Y ☐ **N** ☐

13. Has the patient experienced benefit from therapy as evidenced by disease stability or disease improvement?
    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