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:** 8/12/2024
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. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. Please request formulary list from patient's plan. Can the patient's treatment be switched to a formulary alternative?

   Yes - Specify formulary alternative. Please submit a new request for formulary alternative. ☐

   _____

   No - Continue request for non-preferred product. ☐

2. Has the patient had a documented inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Please request formulary list from patient's plan.

   Yes - Indicate the formulary alternative(s) the patient has tried and the reason(s) for treatment failure and/or indicate the formulary alternative(s) the patient is unable to take and describe the contraindication(s) ☐

   _____

   No ☐

3. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three, been attached? ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives. **Y** ☐ **N** ☐

4. What is the patient's diagnosis?

   N-acetylglutamate synthase (NAGS) deficiency ☐

   Methylmalonic acidemia ☐

   Propionic acidemia ☐

   Other, please specify. ☐

   _____

5. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

6. Was the diagnosis confirmed by enzymatic, biochemical, or genetic testing? ACTION REQUIRED: If Yes, attach enzyme assay, biochemical or genetic testing results supporting diagnosis of NAGS deficiency. **Y** ☐ **N** ☐

7. Does the patient have elevated plasma ammonia levels at baseline? ACTION REQUIRED: If Yes, attach lab results documenting baseline plasma ammonia levels. **Y** ☐ **N** ☐

8. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

9. Is the patient experiencing benefit from therapy as evidenced by a decrease in ammonia levels from baseline? ACTION REQUIRED: If Yes, attach lab results documenting a reduction in plasma ammonia levels from baseline. **Y** ☐ **N** ☐

10. Is the patient experiencing benefit from therapy as evidenced by disease stability or disease improvement?

- Yes, disease stability ☐
- Yes, disease improvement ☐
- No, neither disease stability nor disease improvement ☐

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