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:** 9/6/2024
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?
   - Neurogenic orthostatic hypotension (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Does the patient have primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure? **Y** ☐ **N** ☐
3. Does the patient have dopamine beta-hydroxylase deficiency? **Y** ☐ **N** ☐
4. Does the patient have non-diabetic autonomic neuropathy? **Y** ☐ **N** ☐
5. Is this a request for continuation of therapy? **Y** ☐ **N** ☐
6. Has the patient experienced a sustained decrease in dizziness since the initiation of therapy? **Y** ☐ **N** ☐
7. Does the patient have a persistent, consistent decrease in systolic blood pressure (SBP) of greater than or equal to 20 mmHg within 3 minutes of standing or head-up tilt test? **Y** ☐ **N** ☐
   ACTION REQUIRED: If Yes, please attach blood pressure readings or documentation of head-up tilt test.
   ACTION REQUIRED: Submit supporting documentation
8. Does the patient have a persistent, consistent decrease in diastolic blood pressure (DBP) greater than or equal to 10 mmHg within 3 minutes of standing or head-up tilt test? **Y** ☐ **N** ☐
   ACTION REQUIRED: If Yes, please attach blood pressure readings or documentation of a head-up tilt test.
   ACTION REQUIRED: Submit supporting documentation

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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