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:** 6/13/2025
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 or the type of procedure the patient will be undergoing?
   - Ovulation induction (e.g., intrauterine insemination [IUI]) (If checked, no further questions) ☐
   - Assisted reproductive technology (e.g., in vitro fertilization, frozen embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, intracytoplasmic sperm injection) (If checked, no further questions) ☐
   - Mature oocyte cryopreservation (If checked, no further questions) ☐
   - Embryo cryopreservation (If checked, no further questions) ☐
   - Preimplantation genetic diagnosis (If checked, no further questions) ☐
   - Central precocious puberty (CPP) (including use as a stimulation test to confirm the diagnosis of CPP) (If checked, go to 2) ☐
   - Prostate cancer (If checked, go to 14) ☐
   - Treatment of advancing puberty and growth failure (If checked, go to 17) ☐
   - Salivary gland tumors (If checked, go to 19) ☐
   - Other, please specify. (If checked, no further questions) ☐

     _____
2. Will the requested drug be used as a stimulation test to confirm the diagnosis of central precocious puberty (CPP)? **Y** ☐ **N** ☐
3. Is the patient currently receiving the prescribed therapy for central precocious puberty (CPP) through a paid pharmacy or medical benefit? **Y** ☐ **N** ☐
4. Is the patient experiencing signs of treatment failure (e.g., clinical pubertal progression, lack of growth deceleration, continued excessive bone age advancement)? **Y** ☐ **N** ☐
5. What is the patient's gender?
   - Male (If checked, go to 6) ☐
   - Female (If checked, go to 7) ☐
6. What is the patient's age?
   - Less than 13 years of age (If checked, no further questions) ☐

13 years of age or older (If checked, no further questions) ☐

7. What is the patient's age?
   - Less than 12 years of age (If checked, no further questions) ☐
   - 12 years of age or older (If checked, no further questions) ☐

8. Has the diagnosis of central precocious puberty (CPP) been confirmed by a pubertal response to a gonadotropin-releasing hormone (GnRH) agonist test or a pubertal level of a third-generation luteinizing hormone (LH) assay? ACTION REQUIRED: If Yes, please attach laboratory report or medical record of a pubertal response to a GnRH agonist test or a pubertal level of a third-generation LH assay.
   ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

9. Does the assessment of bone age versus chronological age support the diagnosis of central precocious puberty (CPP)? — **Y** ☐ **N** ☐

10. What is the patient's gender?
    - Male (If checked, go to 11) ☐
    - Female (If checked, go to 12) ☐

11. How old was the patient at the onset of secondary sexual characteristics?
    - Less than 9 years of age (If checked, go to 13) ☐
    - 9 years of age or older (If checked, no further questions) ☐

12. How old was the patient at the onset of secondary sexual characteristics?
    - Less than 8 years of age (If checked, go to 13) ☐
    - 8 years of age or older (If checked, no further questions) ☐

13. Has the pathologic cause of central precocious puberty (CPP) been assessed? (e.g., imaging screening for intracranial tumors, genetic testing for familial CPP [e.g., MKRN3 or DLK1 mutations])? — **Y** ☐ **N** ☐

14. Is the patient currently receiving treatment with the requested drug? — **Y** ☐ **N** ☐

15. Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)? — **Y** ☐ **N** ☐

16. Has the patient experienced an unacceptable toxicity while receiving the requested drug? — **Y** ☐ **N** ☐

17. Is the patient less than 18 years of age? — **Y** ☐ **N** ☐

18. Is the patient also requesting or is currently receiving growth hormone? — **Y** ☐ **N** ☐

19. Is the patient currently receiving treatment with the requested drug? — **Y** ☐ **N** ☐

20. Has the patient experienced clinical benefit to therapy while on the current regimen? — **Y** ☐ **N** ☐

21. Has the patient experienced an unacceptable toxicity while on the current regimen? — **Y** ☐ **N** ☐

22. Is the tumor androgen receptor positive? — **Y** ☐ **N** ☐

23. What is the clinical setting in which the requested drug will be used?
    - Recurrent disease (If checked, go to 24) ☐
    - Unresectable disease (If checked, go to 24) ☐
    - Metastatic disease (If checked, go to 24) ☐
    - Other, please specify. (If checked, no further questions) ☐

    _____

24. Will the requested drug be used as a single agent? **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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