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:** 7/18/2024
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?
   - Severe homozygous cystinuria (prevention of cystine stone formation) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
     _____
2. Is this a request for continuation of therapy? **Y** ☐ **N** ☐
3. Has the patient experienced a benefit from therapy (e.g., a decrease in urinary cystine levels compared to pretreatment baseline, reduction in stone formation/growth)? ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results documenting a benefit from therapy. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
4. Has the diagnosis of cystinuria been confirmed by genetic testing showing biallelic mutations/variants in the SLC3A1 or SLC7A9 gene? ACTION REQUIRED: If Yes, attach genetic testing results supporting diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
5. Has the diagnosis been confirmed by stone analysis revealing 100 percent cystine calculi? ACTION REQUIRED: If Yes, please attach stone analysis testing results supporting diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
6. Has the diagnosis been confirmed with the presence of pathognomonic hexagonal cystine crystals visualized on urine microscopy? ACTION REQUIRED: If Yes, please attach urine microscopy supporting diagnosis. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation
7. Is the requested drug being used as an adjunct to high fluid intake, alkali, and diet modification? **Y** ☐ **N** ☐
8. Does the patient have elevated urinary cystine levels at baseline? ACTION REQUIRED: If Yes, attach lab results documenting baseline urinary cystine levels. **Y** ☐ **N** ☐
   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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