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?
   - Cystic fibrosis (If checked, go to 2) ☐
   - Non-cystic fibrosis bronchiectasis (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

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

3. Is the patient experiencing a benefit from therapy with the requested drug as evidenced by disease stability or disease improvement? **Y** ☐ **N** ☐

4. What is the diagnosis?
   - Cystic fibrosis (If checked, go to 5) ☐
   - Non-cystic fibrosis bronchiectasis (If checked, go to 6) ☐

5. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

6. Does the patient have Pseudomonas aeruginosa present in airway cultures? **Y** ☐ **N** ☐

7. Does the patient have a history of Pseudomonas aeruginosa infection or colonization in the airways? **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