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 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?
   - Infantile spasms (If checked, go to 2) ☐
   - Complex partial seizures (If checked, go to 5) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving therapy with the requested medication? **Y** ☐ **N** ☐

3. Has the patient shown substantial clinical benefit from vigabatrin therapy? **Y** ☐ **N** ☐

4. Is the patient less than 2 years of age? **Y** ☐ **N** ☐

5. What is the prescribed product?
   - Sabril (If checked, go to 6) ☐
   - vigabatrin (If checked, go to 6) ☐
   - Vigadrone (If checked, go to 6) ☐
   - Vigafyde (If checked, no further questions) ☐
   - Vigpoder (If checked, go to 6) ☐

6. Is the patient currently receiving therapy with the requested medication? **Y** ☐ **N** ☐

7. Has the patient shown substantial clinical benefit from vigabatrin therapy? **Y** ☐ **N** ☐

8. Has the patient had an inadequate response to at least 2 alternative treatments for complex partial seizures? If yes, indicate the number of alternative treatments. **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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