Prescriber Criteria Form Impavido 2025 PA Fax 3705-A v1 010125.docx Impavido (miltefosine) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Impavido (miltefosine).

Drug Name: Impavido (miltefosine)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for any of the following: A) visceral leishmaniasis caused by Leishmania donovani, B) cutaneous leishmaniasis caused by Leishmania braziliensis, Leishmania guyanensis, or Leishmania panamensis, C) mucosal leishmaniasis caused by Leishmania braziliensis? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient 12 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient weigh 30 kilograms (66 pounds) or more? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient pregnant? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have Sjogren-Larsson-Syndrome?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____