

Prescriber Criteria Form

Nebs-Mucolytics 2025 PA Fax BD-10 v1 010125.docx
 Inhalation Solutions – Mucolytics
 Acetylcysteine (acetylcysteine), Pulmozyme (dornase alfa)
 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 Inhalation Solutions – Mucolytics.

Drug Name (select from list of drugs shown):

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 patient using the requested drug with a nebulizer? [If no, then no further questions.]	Yes	No
2	Is the request for dornase alfa (Pulmozyme)? [If no, then skip to question 4.]	Yes	No
3	Does the patient have a diagnosis of cystic fibrosis (ICD-10 diagnosis code E84.0)? [No further questions.]	Yes	No
4	Is the request for acetylcysteine? [If no, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of persistent thick or tenacious pulmonary secretions associated with ICD-10 diagnosis codes A22.1, A37.01, A37.11, A37.81, A37.91, A48.1, B25.0, B44.0, B77.81, E84.0, J09.X1-J09.X3, J09.X9, J10.00, J10.01, J10.08, J10.1, J10.2, J10.81-J10.83, J10.89, J11.00, J11.08, J11.1, J11.2, J11.81-J11.83, J11.89, J12.0-J12.3, J12.81, J12.89, J12.9, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3-J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9, J40, J41.0, J41.1, J41.8, J42, J43.0-J43.2, J43.8, J43.9, J44.0, J44.1, J44.81, J44.89, J44.9, J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998, J47.0, J47.1, J47.9, J60, J61, J62.0, J62.8, J63.0-J63.6, J64, J65,	Yes	No

	J66.0-J66.2, J66.8, J67.0-J67.9, J68.0-J68.4, J68.8, J68.9, J69.0, J69.1, J69.8, J70.0-J70.5, J70.8, J70.9?		
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Comments:	
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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: _____
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