Prescriber Criteria Form Nitisinone 2025 PA Fax 579-A v1 010125.docx Nityr, Orfadin (nitisinone) 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 Nitisinone.

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	Does the patient have a diagnosis of hereditary tyrosinemia type 1 (HT-1)? [If no, then no further questions.]	Yes ◯	No ◯
2	Was the diagnosis confirmed by one of the following: A) biochemical testing (e.g., detection of succinylacetone in urine), B) deoxyribonucleic acid (DNA) testing (mutation analysis)?	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:**_____