Prescriber Criteria Form

Pulmozyme BDC 2024 PA Fax 563-A BD-10 v1 010124.docx
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 Pulmozyme (dornase alfa).

Drug Name:
Pulmozyme (dornase alfa)

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.			
B vs D CRITERIA FOR DETERMINATION			
1	Is the patient using the requested drug with a nebulizer? [If no, then skip to question 3.]	Yes	No
2	Does the patient have a diagnosis of cystic fibrosis (ICD-10 diagnosis code E84.0)? [If yes, then no further questions.]	Yes	No
CRITERIA FOR APPROVAL			
3	Does the patient have a diagnosis of cystic fibrosis? [If no, then no further questions.]	Yes	No
4	Will the requested drug be used in conjunction with standard therapies for cystic fibrosis?	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:**_____