



PRIOR AUTHORIZATION REQUEST

CARDAMYST

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL PA requests**. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

- | | | | |
|---|--|-----|----|
| 1 | Is this request for initial therapy or for a continuation of therapy? | | |
| | ☐ Initial (If checked, go to 7) | | |
| | ☐ Continuation (If checked, go to 2) | | |
| 2 | Is the patient currently receiving the requested medication?
[If no, skip to question 7.] | Yes | No |
| 3 | Has the patient been receiving medication samples for the requested medication? | Yes | No |

If you have any
questions, call:
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[If yes, skip to question 7.]

- | | | | |
|----|--|-----|----|
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?
[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If no, skip to question 7.] | Yes | No |
| 5 | Has the patient been established on therapy for at least 3 months?
[If no, skip to question 7.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.
[No further questions.] | Yes | No |
| 7 | What is the diagnosis or indication?

☐ Paroxysmal supraventricular tachycardia (PSVT) (If checked, go to 8)

☐ Other (If checked, no further questions) | | |
| 8 | Is the patient 18 years of age or older?
[If no, no further questions.] | Yes | No |
| 9 | Has electrographical documentation been submitted to confirm a history of PSVT with a mean of 8 PSVT episodes in past year. ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 10 | Does the patient have a history of sustained PSVT episodes, with a duration of approximately greater than or equal to 20 minutes? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 11 | Does the patient have a history of a systolic blood pressure of less than 90 mmHg, a history of severe hypotension, or syncope during PSVT episodes? ACTION REQUIRED: Submit supporting documentation.
[If yes, no further questions.] | Yes | No |
| 12 | Does the patient have a history of atrial arrhythmia NOT involving the AV node? ACTION REQUIRED: Submit supporting documentation.
[If yes, no further questions.] | Yes | No |
| 13 | Does the patient have evidence of ventricular pre-excitation, or second- or third-degree AV block on ECG? ACTION REQUIRED: Submit supporting documentation.
[If yes, no further questions.] | Yes | No |
| 14 | Has the patient had a severe ventricular arrhythmia or a history of acute coronary syndrome? ACTION REQUIRED: Submit supporting documentation.
[If yes, no further questions.] | Yes | No |

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15	Has the patient been diagnosed with heart failure (NYHA Class II-IV)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
16	Has the patient experienced a stroke within the last 6 months? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
17	Has the patient has been diagnosed with Wolff-Parkinson White (WPW), Lown-Ganong Levine (LGL) syndromes or manifest pre-excitation (delta wave) confirmed via a 12-lead electrocardiogram (ECG)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
18	Has the patient been diagnosed with Sick sinus syndrome without a permanent pacemaker? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
19	Has the patient tried beta blockers and experienced inadequate efficacy or an intolerance to beta blockers? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has the patient tried calcium channel blockers and experienced inadequate efficacy or an intolerance to calcium channel blockers? [If no, no further questions.]	Yes	No
21	Does the patient have a history of allergic reaction to verapamil? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
22	Is the patient currently receiving digoxin, any Class I or III antiarrhythmics, or oral amiodarone? [If yes, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with a cardiologist? [If no, no further questions.]	Yes	No
24	Does the dose of the requested medication exceed FDA approved label dosing for the requested indication? [Note: Dosing is one spray in each nostril at the onset of PSVT symptoms = 70 mg. Max dose 140 mg in 24 hrs.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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