

Prescriber Criteria Form

Nitisinone 2024 PA Fax 579-A v1 010124.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:** \_\_\_\_\_