

Prescriber Criteria Form  
 Nebs-Mucolytic 2026 PA Fax BD-10 v1 010126.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:**

<b>Patient DOB:</b>	<b>Patient Phone:</b>
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**Prescriber Name:**

**Prescriber Address:**

<b>City:</b>	<b>State:</b>	<b>Zip:</b>
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<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>
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<b>Diagnosis:</b>	<b>ICD Code(s):</b>
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**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.

<b>Prescriber (or Authorized) Signature:</b> _____	<b>Date:</b> _____
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