Prior Authorization Form

Hyperinflation/Non-Covered Drugs Medical Necessity

CareFirst Family of health care plans

INSTRUCTIONS

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 1-888-836-0730. Please contact CVS/Caremark at 1-800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Hyperinflation Non-Covered Drugs Medical Necessity.

DRUG INFORMATION

Drug Name (specify drug)			Quantity
Frequency	Strength	Route of Administration	Expected Length of Therapy

PATIENT INFORMATION

Patient Name			
Patient ID	Patient Group No.	Patient DOB	Patient Phone

PRESCRIBING PHYSICIAN

Physician Name	Physician Phone	Physician Fax
Physician Address		
City	State	Zip

ADDITIONAL INFORMATION

Diagnosis	**ICD Code**
Comments	

Please check the appropriate answer for each question.

1. The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? (If yes, provide your patient with a new prescription for the formulary product.) Available Formulary Alternatives: See Preferred Drug List.	◯ Yes ◯ No
2. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	◯ Yes ◯ No
3. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	◯ Yes ◯ No
4. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives. If yes, then documentation is required for approval (Drug Name and Reason for Failure). **Note:** Formulary alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: See Preferred Drug List (If yes, no further questions.)	◯ Yes ◯ No
Does the patient have a contraindication to all the alternatives?	◯ Yes ◯ No

SIGNATURE

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (or Authorized) Signature and Date