

Prior Authorization Form

Emverm Post Limit

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 Emverm Post Limit.

Drug Name (select from list of drugs shown)

Albenza Tablets (albendazole) Biltricide Tablets (praziquantel) Emverm (mebendazole)

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: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

- Please circle the appropriate answer for each question.**
1. Is the requested drug being prescribed for the treatment of toxocarasis at a dose equal to or less than 4 tablets per day for 5 days? Y N
2. Has the infection been confirmed by a diagnostic or laboratory test (e.g. blood test)? Y N

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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date