CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

Tretinoin Products

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 Tretinoin Products.

Drug Name (select from list of drugs shown)
(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: ______________________

Diagnosis: ______________________ **ICD Code:** ______________________

Comments: ______________________

Please circle the appropriate answer for each question.	
1. Does the patient have the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)?	Y N

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

Prescriber (Or Authorized) Signature and Date

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