CAREFIRST DC

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:

Patient Phone:

Patient ID:

Patient Group No:

Patient DOB:

Prescribing Physician

Physician Name:

Physician Phone:

Physician Fax:

Physician Address:

City, State, Zip:

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for a corticosteroid-responsive dermatosis or condition (e.g., atopic dermatitis, eczema, psoriasis, seborrheic dermatitis)?	**Y** ☐	**N** ☐
2.	Does the patient require more than 180gm or 180mL or 2 rolls of tape per month?	**Y** ☐	**N** ☐
3.	Is this request for any of the following LOW potency products: A) Alclometasone, B) Desonide, (Desonate, DesOwen, Tridesilon, Verdeso foam), C) Fluocinolone acetonide 0.01 percent, (Synalar solution), D) Hydrocortisone 1, 2, or 2.5 percent, (Ala-Scalp, Texacort), E) Hydrocortisone acetate 2.5 percent cream, (MiCort HC)?	**Y** ☐	**N** ☐
4.	Is this request for an oil, shampoo, or spray? [Oil examples are Derma-Smoothe/FS, Shampoo examples are Capex, Clobex, Spray examples are Clobex, Kenalog, Sernivo, Topicort]	**Y** ☐	**N** ☐
5.	Does the patient require more than 240gm or 240mL per month?	**Y** ☐	**N** ☐
6.	Is this request for any of the following: A) Fluocinolone acetonide 0.025 percent, (Synalar 0.025 percent), B) Flurandrenolide cream, lotion, (Cordran cream, Cordran lotion), C) Fluticasone lotion (Cutivate lotion)?	**Y** ☐	**N** ☐
7.	Does this request exceed 240gm or 240mL per month?	**Y** ☐	**N** ☐
8.	Is this request for Trianex (triamcinolone acetonide 0.05 percent ointment)?	**Y** ☐	**N** ☐
9.	Does this request exceed 430 grams per month?	**Y** ☐	**N** ☐

10. Does this request exceed 540gm or 540mL per THREE months? **Y** ☐ **N** ☐

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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.