

CAREFIRST VA RISK VF DPP-4 Inhibitors Step Therapy (VF Standard)

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 877-203-1681 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of DPP-4 Inhibitors Step Therapy (VF Standard).

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. Has the patient been receiving the requested drug for at least 3 months? Y N
- 2. Has the patient demonstrated a reduction in A1c (hemoglobin A1c) since starting this therapy? Y N
- 3. Does the patient have the diagnosis of type 2 diabetes mellitus? Y N
- 4. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to metformin? Y N
- 5. Does the patient require combination therapy AND have an A1c (hemoglobin A1c) of 7.5 percent or greater? 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

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