Prior Authorization Form

CAREFIRST

Diabetic Test Strips (FA-EXC)*

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 **1-888-487-9257**.
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 Diabetic Test Strips (FA-EXC)*.

Drug Name (select from list of drugs shown)
Other, Please specify

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. Preferred products are available at a lower cost. Can your patient be switched to a preferred product? [If yes, provide your patient with a new prescription for the preferred product.]	Y N
Available Formulary Alternatives: Accu-Chek products	
2. Does the patient have an insulin pump that is incompatible with Accu-Chek products?	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