Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Doxepin Cream Step Therapy (HMF)

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 **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Doxepin Cream Step Therapy (HMF).

Drug Name (select from list of drugs shown)
Doxepin Cream

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 short-term (up to 8 days) management of moderate pruritus in an adult patient with atopic dermatitis or lichen simplex chronicus?	Y N
2. Has the patient experienced an inadequate response to any of the following: A) topical corticosteroid, B) topical tacrolimus (Protopic), C) pimecrolimus (Elidel), D) Eucrisa (crisaborole)?	Y N
3. Does the patient require more than the plan allowance of 90 grams per month?	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