

**Egrifita
Prior Authorization Request**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____	Date: _____
Patient's ID: _____	Patient's Date of Birth: _____
Physician's Name: _____	NPI#: _____
Specialty: _____	Physician Office Fax: _____
Physician Office Telephone: _____	
Request Initiated For: _____	

1. What is the diagnosis? HIV Other _____
2. What is the ICD-10 code? _____
3. Is Egrifita prescribed by or in consultation with an infectious disease specialist? Yes No
4. Is the patient currently receiving anti-retroviral therapy? Yes No
5. Is Egrifita requested to reduce excess abdominal fat in an HIV-infected patient with lipodystrophy? Yes No
6. Is Egrifita requested for weight loss? Yes No
7. Is the patient currently taking Egrifita? Yes No *If No, no further questions*
8. Has the patient demonstrated a clear clinical improvement from baseline that is supported by a waist circumference and/or CT scan? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Egrifita SGM - 7/2017.

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