Prior Authorization Form

CAREFIRST BCBS

GST Acne (HP)

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 **1-877-203-0003** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of GST Acne (HP).

Drug Name (select from list of drugs shown)

Azelex (azelaic acid)	Clindagel (clindamycin)	Fabior (tazarotene)
Riax (benzoyl peroxide foam)	Tretin-X (tretinoin)	

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.

Formulary alternatives may include but are not limited to: Benzoyl peroxide, clindamycin topical, clindamycin/benzoyl peroxide, erythromycin topical, erythromycin/benzoyl peroxide, sodium sulfacetamide, or sodium sulfacetamide/sulfur.

1. Has the patient demonstrated an inadequate treatment response after at least a 30 day trial of a generic acne product? Y N

[If yes, then no further questions.]

2. Does the patient have a documented contraindication to or a potential drug interaction with a generic acne product? Y N

	[If yes, then no further questions.]
3.	Has the patient had a trial and was intolerant to at least one generic acne product? 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