Prior Authorization Form

CAREFIRST

Reltone

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 **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Reltone.

Drug Name (select from list of drugs shown)

Reltone (ursodiol capsules) Ursodiol Capsules [Brand]

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. Does the patient have radiolucent, noncalcified gallbladder stones less than 20 millimeters in greatest diameter? Y N

[If no, then skip to question 4.]

2. Is the request for a patient in whom elective cholecystectomy would be undertaken except for the presence of any of the following: A) Increased surgical risk due to systemic disease, advanced age, or idiosyncratic reaction to general anesthesia, B) Patient refuses surgery? Y N

[If no, then no further questions.]

3. Can the patient use generic ursodiol 300 mg capsules? Y N

	[No further questions.]	
4.	Is the requested drug being prescribed for the prevention of gallstone formation in an obese patient experiencing rapid weight loss?	Y N
	[If no, then no further questions.]	
5.	Has the patient experienced an intolerance to generic ursodiol 300 mg capsules due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	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