CAREFIRST

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group:

Patient DOB: / /

Physician Information

Physician Name

Physician Phone: - -

Physician Fax: - -

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Voriconazole Vfend (voriconazole)

Quantity: ____________ **Frequency:** __________________ **Strength:** __________________

Route of Administration: _______________________ **Expected Length of Therapy:** _____________________

Diagnosis: ________________________________ **ICD Code:** _________________________

Comments: ____

____

Please check the appropriate answer for each applicable question.

1. Is the requested drug being prescribed for any of the following: A) treatment of invasive aspergillosis (including invasive pulmonary aspergillosis), B) serious fungal infection caused by Scedosporium apiospermum and Fusarium species, C) prophylaxis of invasive aspergillosis in a high-risk patient, D) chronic pulmonary aspergillosis, E) empiric antifungal therapy for febrile neutropenia in a high-risk patient, F) mycosis due to Scedosporium prolificans? **Y** ☐ **N** ☐
2. Is the requested drug being prescribed for any of the following: A) candidemia in a non-neutropenic patient, B) disseminated Candida infection in the skin, C) Candida infection in the abdomen, kidney, bladder wall, or wounds, D) esophageal candidiasis, E) oropharyngeal candidiasis? **Y** ☐ **N** ☐
3. Has the patient experienced an inadequate treatment response to an alternative antifungal therapy? **Y** ☐ **N** ☐
4. Has the patient experienced an intolerance to an alternative antifungal therapy? **Y** ☐ **N** ☐
5. Does the patient have a contraindication that would prohibit a trial of an alternative antifungal therapy? **Y** ☐ **N** ☐
6. Will the patient be using the requested drug orally or intravenously? **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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.