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 800-294-5979 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 No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (select from list of drugs shown)

Zileuton ER Zyflo (zileuton) Zyflo CR (zileuton ER)

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 this request for continuation of therapy with the requested medication? **Y** ☐ **N** ☐

2. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? **Y** ☐ **N** ☐

3. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

4. Is the requested drug being used for the prophylaxis and chronic treatment of persistent asthma? **Y** ☐ **N** ☐

5. Does the patient have active liver disease or persistent liver enzyme elevations greater than 3 times the upper limit of normal? **Y** ☐ **N** ☐

6. Has the patient experienced a failure, contraindication, or intolerance to an oral inhaled corticosteroid? [Action required: If 'Yes', attach supporting chart note(s) or other documentation supporting date of trial and reason for intolerance to an oral inhaled corticosteroid.] **Y** ☐ **N** ☐

   _____

7. Has the patient experienced a failure, contraindication, or intolerance to Singular (montelukast) AND Accolate (zafirlukast) for asthma? [Action required: If 'Yes', attach supporting chart note(s) or other documentation supporting date of trial and reason for intolerance to Singulair (montelukast) and Accolate (zafirlukast).] **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

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