hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

CVS/caremark™

HMSA ASO

ACF Non-Covered Drugs Medical Necessity

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 **1-855-762-5207**.
Please contact CVS/Caremark at **1-855-582-2026** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of ACF Non-Covered Drugs Medical Necessity.

Drug Name (specify drug) _____

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.	Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y N	
2.	Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? (IF YES, PLEASE DOCUMENT DRUG NAME, TRIAL YEAR AND REASON FOR FAILURE)	Y N	
	[If yes, then no further questions.]		
3.	Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? (IF YES, PLEASE DOCUMENT THE REASON(S) THE PATIENT CANNOT TRY THE FORMULARY ALTERNATIVES)	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date