09/23/2013

Prior Authorization Form

HMSA FI

Tiering Exception

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 **1-855-240-0543** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Tiering Exception.

Drug Name (select from list of drugs shown)

Other, Please specify

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 Other Brand (Tier 3) drug a controlled substance (that is, Schedule II, III, IV, or V)? Y N

   [If the answer to this question is yes, no further questions are required.]

2. Does the requested Other Brand (Tier 3) drug have a generic equivalent available? Y N

   [If the answer to this question is yes, no further questions are required.]

3. Is the requested drug a Tier 4 Specialty drug? Y N

   [If the answer to this question is yes, no further questions are required.]

4. Is the requested drug being used for a chronic condition lasting 3 or more months? Y N

   [If the answer to this question is no, no further questions are required.]

5. Is the requested Other Brand (Tier 3) drug being used for an Y N

FDA-approved indication?

[If the answer to this question is no, no further questions are required.]

6. Has the patient exhibited intolerance with OR allergy to OR ineffective treatment response to at least TWO of the formulary alternatives? Y N

[Note: If only one alternative is available, that formulary agent must have been ineffective.]

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

____

Prescriber (Or Authorized) Signature and Date