Formulary Exception/Prior Authorization Request Form

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Patient ID#:				
Address:		Address:		
City:	State:	City:		State:
Home Phone:	ZIP:	Office Phone #:	Office Fax #:	ZIP:
Gender: M or F	DOB:	Contact Person at Doctor's Office:		

Diagnosis and Medical Information			
Medication:	Strength:	Frequency:	
Expected Length of Therapy:	Qty:	Day Supply:	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis:		Diagnosis (ICD) Code(s):	

FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

What condition is the drug being prescribed for? _____

Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug and trial year: _____

Drug(s) contraindicated: _____

Adverse event (e.g., toxicity, allergy) for each drug: _____

Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? Specify anticipated significant adverse event:
_____

Does the patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____ _____

Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____

Are additional risk factors present (e.g., gastrointestinal (GI) risk, cardiovascular risk, age)? If so, please provide risk factors:
_____

Other: Please provide additional relevant information: _____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.

PLEASE COMPLETE CORRESPONDING SECTION ON PAGE 2 FOR THE SPECIFIC DRUGS/CLASSES LISTED.

FOR ANY DRUG/CLASS NOT LISTED ON PAGE 2, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES.

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS.

PLEASE FAX COMPLETED FORM TO 1-888-836-0730.

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 documentation supporting this information is available for review if requested by CVS Caremark™, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____

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PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS:**
1. Does the patient have a diagnosis of onychomycosis? ***Yes or No***
   If yes to question 1, is the onychomycosis confirmed by a fungal diagnostic test? ***Yes or No***
2. Does the infection involve the toenails, fingernails or both? ***(Please circle)***
3. Does the patient have a diagnosis of Tinea corporis or Tinea cruris? ***Yes or No***
   If yes to question 3, does the patient require systemic therapy or have more extensive superficial infections? ***Yes or No***
4. Is the request for topical medication? ***Yes or No***
5. Has the patient experienced an inadequate treatment response, intolerance or contraindication to an oral antifungal therapy? ***Yes or No***

☐ **ANTIEMETIC (5-HT3) AGENTS:**
1. Is the patient receiving moderate to highly emetogenic chemotherapy or receiving radiation therapy? ***Yes or No***
2. Is the patient at risk for hospitalization for Hyperemesis Gravidarum? ***Yes or No***
   If yes to question 2, has the patient experienced an inadequate treatment response to two of the following medications: Vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? ***Yes or No***

☐ **CELEBREX:**
1. Is the patient being treated for post-operative pain following coronary artery bypass grafting (CABG) surgery? ***Yes or No***
2. Has the patient received a 30-day supply of an anticoagulant, antiplatelet, an oral corticosteroid or a gastrointestinal medication? ***Yes or No***
3. Has the patient had intolerance to or an inadequate treatment response to a traditional non-steroidal anti-inflammatory drugs (NSAIDs) or NSAID/GI combination product? ***Yes or No***
4. Is the drug being prescribed for any of the following diagnoses: osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, acute pain, primary dysmenorrhea or juvenile rheumatoid arthritis? ***Yes or No***

☐ **ERECTILE DYSFUNCTION:**
1. Does the patient require nitrate therapy on a regular OR on an intermittent basis? ***Yes or No***
2. Is the drug being prescribed for erectile dysfunction? ***Yes or No***
3. Is the drug being prescribed for symptomatic Benign Prostatic Hyperplasia (BPH)? ***Yes or No***

☐ **INSOMNIA AGENTS:**
1. Does the patient have a diagnosis of insomnia? ***Yes or No***
2. Have potential causes of sleep disturbances been addressed (e.g., inappropriate sleep hygiene and sleep environment issues, treatable medical/psychological causes of chronic insomnia)? ***Yes or No***

☐ **PROTON PUMP INHIBITORS:**
1. Does the patient have peptic ulcer disease OR frequent and severe symptoms of gastroesophageal reflux disease (GERD) (e.g., heartburn, regurgitation) OR atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? ***Yes or No***
2. Does the patient have Barrett's esophagus OR a Hypersecretory syndrome (e.g. Zollinger-Ellison)? ***Yes or No***
3. Is the patient at high risk for GI adverse events? ***Yes or No***

☐ **PROVIGIL/NUVIGIL:**
1. Does the patient have a diagnosis of Shift Work Sleep Disorder? ***Yes or No***
2. Does the patient have a diagnosis of Obstructive Sleep Apnea confirmed by polysomnography? ***Yes or No***
3. Does the patient have a diagnosis of Narcolepsy confirmed by sleep lab evaluation? ***Yes or No***

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**
1. Does the patient have a diagnosis of attention deficit/hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? ***Yes or No***
2. Has the diagnosis been documented (i.e., complete clinical assessment, using DSM-5®, standardized rating scales)? ***Yes or No***
3. Does the patient have a diagnosis of Narcolepsy confirmed by sleep lab evaluation? ***Yes or No***
4. Does the patient have a diagnosis of moderate to severe binge eating disorder (BED)? ***Yes or No***

☐ **TRETINOIN PRODUCTS:**
1. Does the patient have the diagnosis of acne vulgaris or keratosis follicularis? ***Yes or No***

☐ **TAZORAC:**
1. Does the patient have a diagnosis of acne or plaque psoriasis? ***Yes or No***
2. Will the patient be applying Tazorac to less than 20 percent of body surface area? ***Yes or No***
3. Has the patient had intolerance, inadequate treatment response or contraindication to one topical corticosteroid? ***Yes or No***
4. Is the patient able to bear children? ***Yes or No***
5. Has the pregnancy status of the patient been evaluated? ***Yes or No***
6. Is the patient aware of the potential risks of fetal harm and importance of birth control while using Tazorac? ***Yes or No***

☐ **TESTOSTERONE PRODUCTS:**
1. Does the patient have primary or secondary (hypogonadotropic) hypogonadism? ***Yes or No***
2. Does the patient have age-related hypogonadism? ***Yes or No***
3. Did the patient (or does the patient currently) have two confirmed low testosterone levels or absence of endogenous testosterone before start of testosterone therapy? ***Yes or No***
4. Is the drug being prescribed for female-to-male gender reassignment? ***Yes or No***

☐ **TRIPTANS:**
1. Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? ***Yes or No***
2. Does the patient have a diagnosis of migraine headache or cluster headache? ***Yes or No***
3. Is the patient currently using or unable to use migraine prophylactic therapy (e.g., amitriptyline, propranolol, timolol)? ***Yes or No***
4. Has medication overuse headache been considered and ruled out? ***Yes or No***