



**UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM
CONTAINS CONFIDENTIAL PATIENT INFORMATION**

Complete this form in its entirety and send to:
CVS Caremark, 1300 East Campbell Rd., Richardson, TX 75081
Fax 1-888-836-0730

or fax 1-855-245-2134 for Exchange business

As of January 1, 2020, no prior authorization requirements may be imposed by a carrier for any FDA-approved prescription medication on its formulary which is approved to treat substance use disorders.

<input type="checkbox"/> Urgent ¹		<input type="checkbox"/> Non-Urgent	
Requested Drug Name:			
Is this drug intended to treat opioid dependence?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes , is this a first request within a 12-month period for prior authorization for this drug? * If Yes , prior authorization is not required for a 5-day supply of any FDA-approved drug for the treatment of opioid dependence, and there is no need to complete this form. *If No , as of January 1, 2020, a prior authorization is not required for prescription medications on the carrier's formulary, and there is no need to complete this form.		Yes* <input type="checkbox"/>	No* <input type="checkbox"/>
Patient Information:		Prescribing Provider Information:	
Patient Name:		Prescriber Name:	
Member/Subscriber Number:		Prescriber Fax:	
Policy/Group Number:		Prescriber Phone:	
Patient Date of Birth (MM/DD/YYYY):		Prescriber Pager:	
Patient Address:		Prescriber Address:	
Patient Phone:		Prescriber Office Contact:	
Patient Email Address:		Prescriber NPI:	
		Prescriber DEA:	
Prescription Date:		Prescriber Tax ID:	
		Specialty/Facility Name (If applicable):	
		Prescriber Email Address:	
Prior Authorization Request for Drug Benefit:		<input type="checkbox"/> New Request <input type="checkbox"/> Reauthorization	
Patient Diagnosis and ICD Diagnostic Code(s):			
Drug(s) Requested (with J-Code, if applicable):			
Strength/Route/Frequency:			
Unit/Volume of Named Drug(s):			
Start Date and Length of Therapy:			
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:			
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]			
For use in clinical trial? (If yes, provide trial name and registration number):			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:		Route:	Frequency:
Quantity		Number of Refills:	
Product will be delivered to:	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			
<input type="checkbox"/> Approved		<input type="checkbox"/> Denied	
If denied, provide reason for denial and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:			

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request; or is a prior authorization request for medication-assisted treatment for substance abuse disorders.