CLINICAL PRIOR AUTHORIZATION CRITERIA REQUEST FORM

Please complete this form and fax it to CVS Caremark at 1-866-255-7569 to receive a DRUG SPECIFIC CRITERIA FORM for prior authorization. Once received, a DRUG SPECIFIC CRITERIA FORM will be faxed to the specific physician along with patient specific information, appropriate criteria for the request and questions that must be answered. Once received, reviewed and approved an override will be processed and the pharmacist can resubmit the claim for payment. If the request is denied, the physician and patient will be sent a notification and reason for the denial.

ALL fields must be completed before faxing. Please fax the completed form to CVS Caremark at 1-866-255-7569.

SECTION I: PATIENT INFORMATION

LAST NAME, FIRST NAME (PLEASE PRINT)	DOB (MM/DD/YYYY)
STREET ADDRESS	PHONE NUMBER ( )
CITY	STATE
CARDHOLDER ID #	ZIP CODE

SECTION II: DRUG INFORMATION

DRUG NAME (PLEASE PRINT)	DRUG STRENGTH

SECTION III: PHYSICIAN INFORMATION

PHYSICIAN NAME (PLEASE PRINT)	
PHYSICIAN ADDRESS (STREET, CITY, STATE, ZIP CODE)	
PHYSICIAN PHONE NUMBER ( )	PHYSICIAN FAX NUMBER ( )

SIGNATURE	DATE

DISCLAIMER: Incomplete or illegible forms and missing fields may delay the processing of your request. Please complete all fields to ensure appropriate processing.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

PRIVACY DISCLAIMER: Plan participant privacy is important to us. Our employees are trained regarding the appropriate way to handle plan participants' private health information.

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