Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Brand Penalty 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 **1-888-487-9257**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Brand Penalty 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. Has the patient experienced an inadequate treatment response (tried and failed) with the generic alternative?	Y N
[If the answer to this question is yes, no further questions required.]	
2. Has the prescriber determined that the generic alternative is not appropriate based on a specific clinical concern (e.g. allergy)?	Y N
[If the answer to this question is yes, no further questions required.]	
3. Has the patient been stabilized on a brand name medication for a specific clinical condition (e.g. fragile epilepsy, transplant immunosuppression, etc.)?	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