Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

E.E.E. Granules/Eryped (FA-PA)

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of E.E.E. Granules/Eryped (FA-PA).

Drug Name (select from list of drugs shown)

E.E.S. Granules (erythromycin ethylsuccinate) Eryped (erythromycin ethylsuccinate)

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. The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? [If yes, provide your patient with a new prescription for the preferred product.] Y N

Available Formulary Alternatives: erythromycins

2. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Y N

3.	Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	Y N
4.	Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below [If yes, then documentation is required for approval.] Drug Name and Reason for Failure	Y N
	Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 1 in a class with 1 alternatives, erythromycins	
	[If yes, no further questions.]	
5.	Does the patient have a contraindication to all the alternatives?	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