Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Exforge HCT (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 Exforge HCT (FA-PA).

Drug Name (select from list of drugs shown)
Exforge HCT (amlodipine-valsartan-hctz)

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. Preferred products are available at a lower cost. Can your patient be switched to a preferred drug/product? [If yes, provide your patient with a new prescription for the preferred product.] Y N

Available Formulary Alternatives: amlodipine-valsartan-hydrochlorothiazide, olmesartan-amlodipine-hydrochlorothiazide

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: 2 in a class with 2 alternatives, amlodipine-valsartan-hydrochlorothiazide, olmesartan-amlodipine-hydrochlorothiazide	
	[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