

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Initial Benefit Review (NonClinic)

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 **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Initial Benefit Review (NonClinic).

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. This criteria is to be used for Initial Benefit Review

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