Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

New to Market Drugs Medical Necessity (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 New to Market Drugs Medical Necessity (FA-PA).

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.	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
2.	Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Micromedex, current accepted guidelines)?	Y N
3.	Has the patient had an inadequate treatment response or intolerance to all formulary alternatives for the given	Y N

	diagnosis (or to at least 1 agent within each of a given class of agents when more than 1 class is available for the diagnosis)?	
	[If yes, then no further questions.]	
4.	Does the patient have a contraindication to all formulary alternatives?	Y N
	[If yes, then no further questions.]	
5.	Is this the only FDA-Approved product to treat the patient's diagnosis?	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