

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION  
Noritate (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 Noritate (FA-PA).

Drug Name (select from list of drugs shown)

Noritate (metronidazole)

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.  Y  N  
Can your patient's treatment be switched to a formulary drug? [If yes, provide your patient with a new prescription for the preferred product.]

Available Formulary Alternatives: metronidazole, Finacea, Soolantra

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?	<input type="checkbox"/> Y <input type="checkbox"/> 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 _____	<input type="checkbox"/> Y <input type="checkbox"/> N
<p>Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 3 in a class with 3 alternatives, metronidazole, Finacea, Soolantra</p>	
<p>[If yes, no further questions.]</p>	
5. Does the patient have a contraindication to all the alternatives?	<input type="checkbox"/> Y <input type="checkbox"/> N

I affirm that the information given on this form is true and accurate as of this date.

<b>Prescriber (Or Authorized) Signature and Date</b>