Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Prudoxin, Zonalon Step Therapy

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 Prudoxin, Zonalon Step Therapy .

Drug Name (select from list of drugs shown)

Doxepin 5% Cream Prudoxin (doxepin 5% cream) Zonalon (doxepin 5% cream)

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 prescribed for short-term (up to 8 days) management of moderate pruritus in an adult patient with atopic dermatitis or lichen simplex chronicus?	Y N
2.	Has the patient experienced an inadequate response to any of the following: A) topical corticosteroid, B) topical tacrolimus (Protopic), C) Elidel (pimecrolimus)?	Y N
3.	Is the patient treating more than 10 percent of body surface area AND requires more than 90 grams?	Y N
	[If no, then no further questions.]	
4.	Does the patient require more than 180 grams?	Y N

[Note: Coverage is provided for 180 grams per month.]

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

Prescriber (Or Authorized) Signature and Date