Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Tazorac

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 Tazorac.

Drug Name (select from list of drugs shown)

Tazarotene Cream | Tazorac (tazarotene) | Tazorac (tazarotene) cream
Tazorac (tazarotene) gel

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.	Does the patient have a diagnosis of acne vulgaris?	Y N
	[If yes, then no further questions.]	
2.	Is the requested drug being prescribed for plaque psoriasis to treat less than 20 percent of the patient's body surface area?	Y N
3.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one topical corticosteroid?	Y N

[Note: The patient may continue to use a corticosteroid product (e.g., clobetasol, fluocinonide, mometasone, triamcinolone, etc.).]

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

Prescriber (Or Authorized) Signature and Date