		Prior Autho	prization Form			
GEHA FEDERAL - STANDARD OPTION Topical Corticosteroids (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 Topical Corticosteroids (FA-PA).						
Drug Name (select from list of drugs shown) Clobetasol Spray Clobex Spray (clobetasol) Olux-E 0.05% (clobetasol proprionate foam)						
Quantity		Frequency		Strength		
Route of Adminis	tration		pected Length o	•		
Patient Information Patient Name: Patient ID: Patient Group No Patient DOB: Patient Phone:				-		
Prescribing Physic Physician Name: Physician Phone: Physician Fax: Physician Addres City, State, Zip:						
Diagnosis:		IC	D Code:			
Comments:						
Please circle the appropriate answer for each question. 1. The patient's drug benefit plan provides coverage for other Y N drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? [If yes, provide your patient with a new prescription for the formulary product.] Available Formulary Alternatives: clobetasol foam						
 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)? 						

3.	Does the prescribed dose and quantity fall within the FDA Y N approved labeling or within dosing guidelines found in the compendia of current literature?			
4.	Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below: Drug Name and Reason for Failure			
	Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives 1 in a class with only 1 alternative: Clobetasol Foam			
	[If yes, no further questions.]			
5.	Does the patient have a contraindication to all the Y N alternatives?			

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

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Prescriber (Or Authorized) Signature and Date					