CareFirst

The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Fabior

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 Fabior.

Drug Name (select from list of drugs shown)
Fabior (tazarotene)

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 the diagnosis of acne vulgaris?	Y N
	[If the answer to this question is no, then no further questions are required.]	
2.	Is the patient female and able to bear children? [If the answer to this question is no, then no further questions are required.]	Y N
3.	Has the pregnancy status of the patient been evaluated and is the patient aware of the potential risks of fetal harm and important of birth control while using Fabior?	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

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