CareFirst
Family of health care plans

CVS caremark™

Prior Authorization Form

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. Is the requested drug being prescribed for acne vulgaris?	Y N
[If yes, then skip to question 4.]	
2. Is the requested drug being prescribed for plaque psoriasis and will it be applied to less than 20 percent of the patient's body surface area?	Y N

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3.	Has the patient tried at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) OR has the patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids?	Y N
	[Note: The patient may still be using a corticosteroid product IN ADDITION TO Tazorac.]	
4.	Is the patient able to bear children?	Y N
	[If no, then no further questions.]	
5.	Has the pregnancy status of the patient been evaluated, and is the patient aware of the potential risks of fetal harm and importance of birth control while using the requested drug?	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