

Prior Authorization Form

CAREFIRST

Epiduo, Epiduo Forte

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 Epiduo, Epiduo Forte.

Drug Name (select from list of drugs shown)

Adapalene-Benzoyl  
Peroxide Gel

Epiduo (adapalene-benzoyl  
peroxide)

Epiduo Forte (adapalene-benzoyl  
peroxide)

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

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

\_\_\_\_\_

**Prescriber (Or Authorized) Signature and Date**