Prior Authorization Form

CAREFIRST MD RISK

Global Step Therapy State of Maryland Mandate REG

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 **1-855-582-2038** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Global Step Therapy State of Maryland Mandate REG.

Drug Name (select from list of drugs shown)

Other, Please specify

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 an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y N
	[If Yes, go to 2. If No, then no further questions.]	
2.	Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Y N
	[If Yes, go to 3. If No, then no further questions.]	
3.	Is the alternate drug FDA-approved for the medical	Y N

	condition being treated?	
	[If Yes, go to 4. If No, then no further questions.]	
4.	Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days?	Y N
	[If Yes, go to 5. If No, go to 6.]	
5.	Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition?	Y N
	[No further questions]	
6.	Is the request for a brand drug that has a generic equivalent or interchangeable biological product available?	Y N
	[If Yes, go to 7. If No, go to 8.]	
7.	Has the patient had a trial and failure of the generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Y N
	[No further questions]	
8.	Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient?	Y N
	[If Yes, then no further questions. If No, go to 9.]	
9.	Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen?	Y N
	[If Yes, then no further questions. If No, go to 10.]	
10.	Is the patient stable on the requested drug for the medical condition under consideration?	Y N
	[If Yes, then no further questions. If No, go to 11.]	
11.	Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Y N
	[No further questions]	

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