

**CAREFIRST VA RISK VF
Influenza Post Limit (VF Standard)**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 877-203-1681 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Influenza Post Limit (VF Standard).

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Drug Name (specify drug) _____

Quantity: _____ Frequency: _____ Strength: _____

Route of Administration: _____ Expected Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please check the appropriate answer for each applicable question.

- 1. Is this request for Xofluza (baloxavir)? Y N
- 2. Is this request for a patient 12 years of age or older for any of the following: A) Treatment of acute uncomplicated influenza, B) Post-exposure prophylaxis of influenza? Y N
- 3. Is the requested drug being prescribed for the prophylaxis (prevention) or the treatment of influenza A or B viral infection? Y N
- 4. Is this request for oseltamivir (Tamiflu) for prophylaxis in a patient 3 months of age or older who has been exposed to a community outbreak? Y N
- 5. Does the patient require more than a 6-week course of therapy of any of the following quantities: A) 42 capsules of 75mg or 45mg, B) 84 capsules of 30mg, C) 540mL/9 bottles of suspension? Y N
- 6. Is this request for a patient with immune deficiencies? Y N
- 7. Does the patient require more than any of the following quantities for 12 weeks: A) 84 capsules of 75mg or 45mg, B) 168 capsules of 30mg, C) 1080mL/18 bottles of suspension? Y N
- 8. Is this request for Relenza (zanamivir) for prophylaxis in a patient 5 years of age or older who has been exposed to a community outbreak? Y N
- 9. Does the patient require more than 60 blisters (30 doses)? Y N

10. Is this request for more than any of the following for this course of therapy: A) Tamiflu (oseltamivir): 10 capsules of 75mg or 45mg; 20 capsules of 30mg; 180mL/3 bottles of suspension, B) Relenza (zanamivir): 20 blisters, C) Xofluza (baloxavir): 2 tablets of 20mg or 40mg; or 40mL/2 bottles of suspension?

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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.