

**CAREFIRST
Self Injectables**

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 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Self Injectables.

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 the requested drug being administered in a physician's office? Y N
- 2. Is the requested drug being administered by the patient, or care provider outside of the physician's office? Y N
- 3. Has the patient and/or caregiver been trained to self administer the medication? Y N
- 4. Has this training been documented in the patient chart? 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.