

**CAREFIRST  
Solaraze**

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 Solaraze.

**Patient Information**

**Patient Name:**   
**Patient Phone:**  -  -   
**Patient ID:**   
**Patient Group:**   
**Patient DOB:**  /  /

**Physician Information**

**Physician Name**   
**Physician Phone:**  -  -   
**Physician Fax:**  -  -   
**Physician Addr.:**   
**City, St, Zip:**

**Drug Name (select from list of drugs shown)**

Diclofenac Sodium 3% Transdermal Gel

**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 [diclofenac sodium gel 3 percent (generic Solaraze)] being prescribed for the treatment of actinic keratoses (AK)? **Y**  **N**
- 2. Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution? **Y**  **N**
- 3. Does the patient require more than the plan allowance of 100 grams per month? **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**

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