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Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Prevention of recurrence of Clostridioides difficile infection (CDI)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the requested drug being used for the treatment of Clostridioides difficile infection (CDI)? ❑ Yes ❑ No
4. Has the patient had three or more episodes of CDI within the past 12 months (including the most recent episode)? ***ACTION REQUIRED: If Yes, attach supporting medical records, chart notes and/or lab test results documenting the episodes of recurrent CDI within the past 12 months are required.*** ❑ Yes ❑ No
5. Did the patient have a recent episode of recurrent CDI with at least three unformed stools per day for two consecutive days? ❑ Yes ❑ No
6. Did the patient have a stool test confirming the presence of C. difficile toxin or toxigenic C. difficile during the patient's recent episode of recurrent CDI? ***ACTION REQUIRED: If Yes, attach supporting medical records, chart notes and/or lab test results of stool test confirming the presence of C. difficile toxin or toxigenic C. difficile.*** ❑ Yes ❑ No
7. Did the patient have a recent episode of recurrent CDI with an adequate clinical response (e.g., resolution of symptoms) following standard of care antibiotic therapy (e.g., vancomycin, fidaxomicin)? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature ***Date (mm/dd/yy)***

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155