Prior Authorization Form

Carefirst Health Exchange MSP-VA Global Formulary Exception
State of Virginia Mandate REG

CareFirst
Family of health care plans

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-855-245-2134**. This fax machine is located in a secure location as required by HIPAA regulations. Please contact Pharmacy at **1-855-582-2022** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Global Formulary Exception State of Virginia Mandate REG.

DRUG INFORMATION			
Drug Name (specify drug)		Route of Administration	
Quantity	Frequency	Strength	Expected Length of Therapy

PATIENT INFORMATION			
Patient Last Name		Patient First Name	M.I.
Patient ID	Group Number	Birth Date	Phone ( )

PRESCRIBING PHYSICIAN		
Physician Name	Phone ( )	Fax ( )
Address		
City	State	ZIP
Diagnosis		**ICD Code**
Comments		

Please check the appropriate answer for each question.	
1. Is the requested product being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	◯ Yes ◯ No
2. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	◯ Yes ◯ No
3. Has the patient been receiving the requested non-formulary prescription medication for at least 6 months prior to a change in the formulary? ***If no, then skip to question 5.***	◯ Yes ◯ No
4. Based on your professional judgement, is the formulary medication an inappropriate therapy for the patient OR will changes to drug therapy present a significant health risk to the patient? ***If yes, then no further questions.***	◯ Yes ◯ No
5. Is the patient unable to take the required number of formulary alternatives for the given diagnosis due to a trial and inadequate treatment response or intolerance or an expected adverse reaction or contraindication? (Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative. If the requested drug is a combination product, at least 1 of the alternatives tried must be the 2 separate individual components taken concurrently plus the remaining required number of alternatives). ***If yes, then no further questions.***	◯ Yes ◯ No
6. Does the patient have a clinical condition or need a specific dosage form for which there is no formulary alternative or the listed formulary alternatives are not recommended based on published guidelines or clinical literature OR the formulary alternatives will likely be ineffective or less effective for the patient OR the formulary alternatives will likely cause an adverse effect?	◯ Yes ◯ No

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	Date

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