

Tretinoin Products – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Fax: 888-836-0730

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 888-836-0730.** If you have questions regarding the prior authorization, please contact CVS/caremark at **800-294-5979**.

Patient Name:	Date:
Patient's ID:	Patient's Date of Birth:
Physician's Name:	
Specialty:	NPI#:
Physician Office Telephone:	Physician Office Fax:
Quantity:	Frequency:
Route of Administration:	Expected Length of Therapy:

1. What drug is being prescribed? _____
2. Does the patient have the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)?
 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)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message.