CAREFIRST
Compounded Drug Products

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 Compounded Drug Products .

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 (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

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Please check the appropriate answer for each applicable question.

1.	Is this request for ANY of the following: A) intravenous (IV) injection or infusion, B) anti-infective for injectable use, C) total parenteral nutrition (TPN), D) leuprolide acetate for infertility in a patient unable to utilize the FDA-approved commercially available product (1mg per 0.2mL kit), E) pyrimethamine, F) hydroxyprogesterone, G) sirolimus for tuberous sclerosis, where other dermatological treatments, (e.g., laser therapy, surgery, dermabrasion) are inappropriate?	**Y** ☐	**N** ☐
2.	Is this request for tacrolimus (Prograf) or everolimus (Zortress) for a patient receiving a transplant?	**Y** ☐	**N** ☐
3.	Is the patient 12 years of age or older?	**Y** ☐	**N** ☐
4.	Is this request for a topical compound or a topical compound kit for use on the skin (e.g., cream, gel, lotion, ointment)?	**Y** ☐	**N** ☐
5.	Do any of the following apply for the requested compound: A) Intended for anti-aging, B) Intended for cosmetic use, C) Is a compound kit, D) Contains a bulk powder, E) Contains a dietary supplement?	**Y** ☐	**N** ☐
6.	Is this request for a hormone therapy compound for menopause OR for androgen decline due to aging (e.g., testosterone, estrogen, progestin, bioidentical hormone)?	**Y** ☐	**N** ☐
7.	Are each of the active ingredients in the compound FDA-approved drugs?	**Y** ☐	**N** ☐
8.	Are each of the active ingredients in the compound FDA-approved for the indication for which the compound is being prescribed?	**Y** ☐	**N** ☐
9.	Is the compound route of administration the same as the FDA-approved route of administration (ROA) for each active ingredient?	**Y** ☐	**N** ☐
10.	Is the dosage or concentration of each active ingredient in the compound equal to or below the FDA-approved dosage or concentration?	**Y** ☐	**N** ☐

11.	Is there a current supply shortage of the commercially manufactured product?	**Y** ☐	**N** ☐
12.	Does the patient have a medical need for a dosage form or dosage strength that is not available commercially or manufactured?	**Y** ☐	**N** ☐
13.	Has the patient had an intolerance or contraindication to the commercially manufactured product (examples may include allergen or adverse effects due to inactive ingredients)?	**Y** ☐	**N** ☐
14.	Has the commercial product been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness?	**Y** ☐	**N** ☐
15.	Does the patient need more than 1 fill per month of the compounded drug (necessity may include continuation of antibiotic therapy, stability is less than a month, dose adjustment)?	**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