

Prior Authorization Form

CareFirst Global Post Step Therapy State of Maryland Mandate REG (HMF)



Family of health care plans

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at 1-888-836-0730. 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 Post Step Therapy State of Maryland Mandate REG (HMF).

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 drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?			Yes No
2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?			Yes No
3. Is the preferred drug FDA-approved for the medical condition being treated? <i>If no, then no further questions.</i>			Yes No
4. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? <i>If no, then skip to question 6.</i>			Yes No
5. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? <i>If yes, then no further questions.</i>			Yes No
6. Has the patient experienced an inadequate treatment response to the preferred drug? <i>If yes, then no further questions.</i>			Yes No
7. Has the patient experienced an intolerance to the preferred drug? <i>If yes, then no further questions.</i>			Yes No
8. Does the patient have a contraindication that would prohibit a trial of the preferred drug?			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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