Formulary Exception/Prior Authorization Request Form

Please return completed form to: 1-888-836-0730

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Patient ID#:				
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Gender: M or F	DOB:	Contact Person at Doctor's Office:		

Diagnosis and Medical Information			
Medication:	Strength:		Frequency:
Expected Length of Therapy:	Qty:	Day Supply:	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis:		**Diagnosis (ICD) Code(s):**	

FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION

PLEASE CHECK ALL BOXES THAT APPLY:

☐ Please list **all medications and dates of therapy** the patient has tried specific to the diagnosis and specify below:

Reason for failure, **including date of therapy**, **for each drug**: _____

Drugs contraindicated (Include rationale): _____

Adverse event (e.g. toxicity, allergy) **for each drug**:_____

☐ Is the request for a patient with one or more chronic conditions (e.gl, psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? Specify anticipated significant adverse event: _____

☐ Does that patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

☐ Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

☐ Other: Please provide additional relevant information: _____

PLEASE COMPLETE CORRESPONDING SECTION ON PAGE 2 FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Insomnia Agents/Proton Pump Inhibitors Provigil/Nuvigil/Stimulants/Tazorac/Tretinoin Products/Testosterone Products/Triptans

****FOR ANY DRUG/CLASS NOT LISTED ON PAGE 2, PLEASE ATTACH RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION****

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

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 documentation supporting this information is available for review if requested by CVS Caremark, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____

PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN**

Does the patient have secondary medical risk factors? Please specify which risk factor(s): _____

Does the patient have a diagnosis of Onychomycosis confirmed with a fungal diagnostic test, and does the infection involve the toenails, fingernails or both? **Please circle**

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? **Yes or No**

☐ **ANTIEMETIC (5-HT3) AGENTS:**

Is the patient receiving moderate to highly emetogenic chemotherapy or receiving radiation therapy? **Yes or No**

If the patient has a diagnosis of Hyperemesis Gravidarum, is the patient a documented risk for hospitalization for rehydration? **Yes or No**

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

- vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? **Yes or No**

☐ **CELEBREX:**

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed)? **Yes or No**

Is the patient being treated for post-operative pain following CABG surgery or have active GI bleeding? **Yes or No**

Has the patient received a 30 days supply of an anticoagulant, antiplatelet, an oral corticosteroid or a gastrointestinal medication? **Yes or No**

Has the patient had intolerance to or an inadequate treatment response to a traditional NSAID or NSAID/GI combination product? **Yes or No**

Is the drug being prescribed for osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, acute pain , primary dysmenorrheal, or juvenile rheumatoid arthritis? **Please circle**

☐ **ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL**

Does the patient require nitrate therapy on a regular OR on an intermittent basis? **Yes or No**

Is it being prescribed for erectile dysfunction ?, **Yes or No** Is the patient using other pharmacological treatments for erectile dysfunction? **Yes or No**

Is the drug being prescribed for Pulmonary Arterial Hypertension (PAH)? **Yes or No**

Is the drug being prescribed for symptomatic Benign Prostatic Hyperplasia (BPH)? **Yes or No**

☐ **INSOMNIA AGENTS:**

Have other treatable medical/psychological causes of chronic insomnia been considered and/or addressed? **Yes or No**

Have appropriate sleep hygiene and sleep environment issues been addressed? **Yes or No**

☐ **PROTON PUMP INHIBITORS:**

Does the patient have frequent and severe symptoms of chronic GERD (e.g., heartburn, regurgitation)? **Yes or No**

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? **Yes or No**

Were the symptoms inadequately controlled with the histamine2-receptor antagonist (H2RA)? **Yes or No**

Is the patient at high risk for GI adverse events? **Yes or No If Yes, why**_____

☐ **PROVIGIL/NUVIGIL:**

Does the patient have a diagnosis of Shift Work Sleep Disorder AND experience excessive sleepiness while working? **Yes or No**

Does the patient have a diagnosis of Obstructive Sleep Apnea confirmed by polysomnography? **Yes or No**

Is the patient currently using continuous positive airway pressure (CPAP) therapy OR is CPAP therapy contraindicated or ineffective for the patient? **Yes or No**

Does the patient have a diagnosis of Narcolepsy, and if so, has the diagnosis been confirmed by sleep lab evaluation? **Yes or No**

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? **Yes or No**

Does the patient have a diagnosis of ADHD or ADD? **Yes or No**

Does the patient have a diagnosis of Narcolepsy, and if so, has the diagnosis been confirmed by sleep lab evaluation? **Yes or No**

☐ **TAZORAC/ TRETINOIN PRODUCTS:**

Does the patient have a diagnosis of Acne Vulgaris or Keratosis Follicularis (Darier's disease, Darier-White disease)? **Yes or No**

Has the patient tried and failed products from the following categories: Salicylic Acid Products OR Benzoyl Peroxide products? **Yes or No**

If the patient is female, has the physician discussed with the patient the potential risks of fetal harm and importance of birth control while using Tazorac? **Yes or No**

Has the pregnancy status of the patient been evaluated? **Yes or No**

Will the patient be applying Tazorac to less than 20 percent of body surface area? **Yes or No**

☐ **TESTOSTERONE PRODUCTS:**

Is the patient being treated for Hypogonadism? **Yes or No**

Did the patient have or does the patient currently have confirmed low testosterone level according to your standard lab reference values? **Yes or No**

☐ **TRIPTANS:**

Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? **Yes or No**

Does the patient have a diagnosis of migraine headache? **Yes or No** Does the patient have a diagnosis of cluster headache? **Yes or No**

Is the patient currently using migraine prophylactic therapy or unable to take prophylactic therapy due to inadequate response, intolerance or contraindication? **Yes or No**

Has medication overuse headache been considered and ruled out? **Yes or No**