Formulary Exception/Prior Authorization Request Form

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

Drug Information		
Medication and Strength:	Directions for use (Frequency):	Expected Length of Therapy:
Qty:	Day Supply:	Has the patient been receiving the requested drug within the last 120 days? ***Yes or No***
Has the requested drug been dispensed at a pharmacy and approved for coverage previously by a prior plan? ***Yes or No***		
How long has the patient been on the requested medication?		

PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION
Solely providing demographic and drug information may not constitute a sufficient request for coverage.
Specific drugs/classes are listed on page 2. For any drugs/classes not listed, please attach relevant clinical documentation.

☐ **Expedited/Urgent Review Requested:** *By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*

Please list all medications the patient has tried specific to the diagnosis and specify below:

- Medication name, reason for failure, including trial year: _____
- Drug(s) contraindicated: _____
- Adverse event (e.g., toxicity, allergy) for each drug: _____

Is the request for a patient with a highly sensitive condition (e.g., psychiatric condition, epilepsy, organ transplant) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If yes, specify anticipated significant adverse event:

_____

Does the patient have a chronic condition confirmed by diagnostic testing? ***If yes, please provide diagnostic test and date***: _____

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

Does the patient have a clinical condition for which other formulary alternatives are not recommended or are contraindicated due to comorbidities or drug interactions based on published clinical literature? If so, please provide documentation including medication names and clinical reasons.

_____

Is the request for Diabetic Test Strips? ***If yes, please answer the two questions below.***

1. Does the patient have an insulin pump? If so, please provide make and model (e.g., OmniPod, MiniMed 530G)_____
2. Does the patient have an insulin pump that is incompatible with Accu-Chek products? ***Yes or No***

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

PLEASE FAX COMPLETED FORM TO 1-888-836-0730.

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:**

1. Does the patient have a diagnosis of onychomycosis of the toenails due to tinea unguium, Trichophyton rubrum or Trichophyton mentagrophytes? ***Yes or No (circle appropriate diagnosis)***
   If yes to question 1, is the onychomycosis confirmed by a fungal diagnostic test? ***Yes or No***
2. Is the request for treatment of tinea corporis or tinea cruris in a patient who is immunocompromised or has extensive or complicated infection? ***Yes or No***
   If yes to question 2, does the patient require systemic therapy or have more extensive superficial infections? ***Yes or No***
3. Has the patient experienced an inadequate treatment response, intolerance or contraindication to an oral antifungal therapy? ***Yes or No***

☐ **ANTIOBESITY:**

1. Has the patient completed at least 16 weeks of therapy with the requested drug? ***Yes or No***
   If yes to question 1 and the request is for Saxenda, has the patient lost at least 4 percent of baseline body weight or has the patient continued to maintain their initial 4 percent weight loss? ***Yes or No***
   If yes to question 1 and the request is for Belviq or Contrave, has the patient lost at least 5 percent of baseline body weight or has the patient continued to maintain their initial 5 percent weight loss? ***Yes or No***
2. Does the patient have a body mass index (BMI) greater than or equal to 30 kg per square meter? ***Yes or No***
3. Does the patient have a body mass index (BMI) greater than or equal to 27 kg per square meter AND has additional risk factors? ***Yes or No***
4. Will the requested medication be used with a reduced calorie diet and increased physical activity? ***Yes or No***

☐ **ERECTILE DYSFUNCTION:**

1. Is the drug being prescribed for erectile dysfunction? ***Yes or No***
2. Is the drug being prescribed for symptomatic Benign Prostatic Hyperplasia (BPH)? ***Yes or No***

☐ **INSOMNIA AGENTS:**

1. Does the patient have a diagnosis of insomnia? ***Yes or No***
2. Have potential causes of sleep disturbances been addressed (e.g., inappropriate sleep hygiene and sleep environment issues, treatable medical/psychological causes of chronic insomnia)? ***Yes or No***

☐ **PROTON PUMP INHIBITORS:**

1. Does the patient have endoscopically verified peptic ulcer disease OR frequent and severe symptoms of gastroesophageal reflux disease (GERD) OR atypical symptoms or complications of GERD ***Yes or No (if yes, please circle one)***
2. Does the patient have Barrett's esophagus as confirmed by biopsy OR a Hypersecretory syndrome (e.g. Zollinger-Ellison) confirmed with a diagnostic test? ***Yes or No (if yes, please circle one)***
3. Is the patient at high risk for GI adverse events? ***Yes or No***

☐ **PROVIGIL/NUVIGIL:**

1. Does the patient have a diagnosis of Shift Work Disorder (SWD)? ***Yes or No***
2. Does the patient have a diagnosis of Obstructive Sleep Apnea confirmed by polysomnography? ***Yes or No***
3. Does the patient have a diagnosis of Narcolepsy confirmed by sleep lab evaluation? ***Yes or No***
4. Is the request for Provigil, and does the patient have a diagnosis of fatigue related to multiple sclerosis? ***Yes or No***
   If yes to question 4, has the patient had an inadequate treatment response, intolerance or contraindication to amantadine? ***Yes or No***

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

1. Does the patient have a diagnosis of attention deficit/hyperactivity disorder (ADHD) or attention deficit disorder (ADD)? ***Yes or No***
2. Has the diagnosis been documented (i.e., complete clinical assessment, using DSM-5®, standardized rating scales, interviews/questionnaires)? ***Yes or No***
3. Does the patient have a diagnosis of Narcolepsy confirmed by sleep study? ***Yes or No***
4. Does the patient have a diagnosis of moderate to severe binge eating disorder (BED)? ***Yes or No***
5. Is the requested drug being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out? ***Yes or No***
6. Is the request for Strattera and will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? ***Yes or No***

☐ **TRETINOIN PRODUCTS:**

1. Does the patient have the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)? ***Yes or No (if yes, please circle one)***

☐ **TESTOSTERONE PRODUCTS:**

1. Does the patient have primary or secondary (hypogonadotropic) hypogonadism? ***Yes or No***
2. Does the patient have age-related hypogonadism? ***Yes or No***
3. Does the patient have at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values? ***Yes or No***
4. Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy? ***Yes or No***

☐ **TRIPTANS:**

1. Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? ***Yes or No***
2. Does the patient have a diagnosis of migraine headache or cluster headache? ***Please circle one***
3. Is the patient currently using or unable to use migraine prophylactic therapy (e.g., amitriptyline, propranolol, topiramate,)? ***Yes or No***
4. Has medication overuse headache been considered and ruled out? ***Yes or No***
5. Does the patient need an amount for treating more than eight headaches per month with a 5-HT1 agonist? ***Yes or No***

☐ **VOLTAREN GEL:**

1. Does the patient have osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrist or elbow? ***Yes or No***
2. Is the treatment with the requested drug necessary due to intolerance or a contraindication to oral nonsteroidal anti-inflammatory (NSAID) drugs? ***Yes or No***
3. Does the patient require more than 1000 grams (10 tubes) per month? ***Yes or No***