CVSHealth

Formulary Exception/Prior Authorization Request Form

Patient Information		Prescriber Information		
Patient Name: Test Patient		Prescriber Name: Dr. Smith RN		
Patient ID#: 12345653				
Address: 34126 Bear Drive		ProviderAddress: 1234 Mamu St.		
City: San Ramon	State: CA	City: San Ramon		State: CA
Home Phone: 925-123-1212	ZIP: 94582	Office Phone #:	Office Fax #:	ZIP: 94582
Gender: F	DOB: 01/01/1973	Contact Person at Doctor's Office: Sandy Millx		

Diagnosis and Medical Information			
Medication: amlodipine	Strength: 10 mg	Frequency: once daily	
Expected Length of Therapy: 6 months	Qty: 1	Day Supply: 30	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis: High Blood pressure		Diagnosis (ICD) Code(s): I10-I16	

FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION

What condition is the drug being prescribed for? _____

Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug: _____

Drug(s) contraindicated: _____

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

Is the request for a patient with one or more chronic conditions (e.g., 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: _____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.

PLEASE COMPLETE CORRESPONDING SECTION ON PAGE 2 FOR THE SPECIFIC DRUGS/CLASSES LISTED.

FOR ANY DRUG/CLASS NOT LISTED ON PAGE 2, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES.

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

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

☐ **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.

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**: 02/10/2022