



Fax Transmittal

From: CVS Caremark® Prior Authorization

You are receiving this fax because you or a member of your practice's staff recently contacted CVS Caremark to request a Prior Authorization related to a CVS Caremark plan member.

You should know, members are filling prescriptions up to 2 days faster when their prescribers consistently use electronic Prior Authorization (ePA). To get started or to learn more about how you can expedite the Prior Authorization process and receive near real-time decisions* by using ePA, visit [Caremark.com/epa](https://www.caremark.com/epa).

Method of submission	Median turnaround time
ePA	< 1 hour
Fax	12 hours

*May not result in near real-time decisions for all prior authorization types and reasons.

If this fax is in response to an inquiry about clinical coverage of a prescription drug for your patient the criteria for the specific drug is attached.

Please note that your inquiry does not constitute a request for coverage. CVS Caremark cannot process a request for coverage until we receive a completed criteria form or appropriate clinical information.

Utilization management decision making is based only on appropriateness of care and service and existence of coverage. CVS Caremark does not reward practitioners or other individuals conducting utilization management for issuing denials of coverage. Financial incentives for utilization management decision makers are not designed to encourage decisions that result in underutilization.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call 1-877-265-2711 at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within 30 days of receipt. The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS Caremark.

91-41319A 101320



Date: 07/06/2023

Sikandar Murad
802 N University Ave
Little Rock, AR 72205

RE: We've approved your request for coverage of Ozempic (2 MG/DOSE) 8MG/3ML SC SOPN.

Dear ATHAR H ANJUM:

We're pleased to let you know that we've approved your or your doctor's request for coverage for Ozempic (2 MG/DOSE) 8MG/3ML SC SOPN. You can now fill your prescription, and it will be covered according to your plan.

As long as you remain covered by your prescription drug plan and there are no changes to your plan benefits, this request is approved from 07/06/2023 to 07/05/2026. When this approval expires, please speak to your doctor about your treatment.

Sincerely,

CVS Caremark®
cc: Dr. Sikandar Murad

If you have questions, we want to help.

Call the number on your prescription ID card or in your plan materials to speak with a representative.



Important notes on approval limitations

Please note, this approval may be limited by:

- Dose or dosing limits, based on U.S. Food and Drug Administration or evidence-based clinical guidance, or by your prescription plan
- Indication, which means the medication may only be covered for certain uses
- National Drug Code (NDC), a number that identifies the medication by manufacturer, dosage form, strength, formulation and package size; some NDCs may not be covered
- Duration, which means this approval will expire on your last day of coverage under your health plan
 - If you do NOT fill your prescription before your coverage ends, your claim may be rejected. You may call the customer service number on the back of your member ID card to confirm your last day of coverage.
- Other limitations according to your prescription benefit plan

This letter addresses the following request for coverage:

PA# AR-BCBS Carriers #3956 #3961 #3963 Exchange 23-073036609 SS

Plan Member Name: ATHAR H ANJUM

Plan Member ID: *****5401

Prescriber Name: Sikandar Murad

Prescriber Phone: 1-5012912322

Prescriber Fax: 1-8883885166

Plan-approved criteria used for review: Antidiabetic Agents Step Therapy (HMF)

Additional resources

The next page provides additional resources if you need help reading or understanding this letter. This is information we are required to provide. You do not need to review it if you don't need further assistance.



Other languages and formats

If you need this document in a different language or format, need someone to read the letter to you, or need help understanding the letter, call Customer Care.

Spanish:

Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):

如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:

Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:

Shika at'ohwol ei doodaii' dinék'ehgo la bi'chí haadeedzihi nínízinígo, t'áá shqodí, t'áá jík'e ya ndaalnishi, ni naaltsoos bikáa'gi bi'chí hodiilnihi.