Prior Authorization Form

CAREFIRST F3 - ACF

Antidiabetic GLP-1, GIP-GLP-1 Agonist PA with Logic

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Antidiabetic GLP-1, GIP-GLP-1 Agonist PA with Logic.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of type 2 diabetes mellitus? Y N

[NOTE: The prescriber MUST submit chart notes documenting a diagnosis of type 2 diabetes mellitus, including a diagnosis code consistent with type 2 diabetes mellitus (e.g., E11.x).]

[If Yes, go to 2. If No, then no further questions.]

2. Have recent chart notes from the past 18 months documenting a diagnosis of type 2 diabetes mellitus, including diagnosis code, been submitted to CVS Health? Y N _____

ACTION REQUIRED: Submit supporting documentation, including diagnosis code.	_____
[No further questions]	

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 and Date