CAREFIRST F3 Aklief

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Aklief.

Patient Information						
Patient Name:						
Patient Phone:						
Patient ID:						
Patient Group:						
Patient DOB:						
Physician Information						
Physician Name						
Physician Phone:						
Physician Fax:						
Physician Addr.:						
City, St, Zip:						
Drug Name (select from list of drugs shown)						
Aklief (trifarotene)						
Quantity:	Frequency: Strength:					
Route of Administration: Expected Length of Therapy:						
Diagnosis:	ICD Code:	_				
Comments:						
Please check th	e appropriate answer for each applicable question.					
	ested drug being prescribed for the topical treatment of acne vulgaris?	Υ		N	ı	
2. Is the request for continuation of therapy?				N	1	
	ient achieved or maintained a positive clinical response as evidenced by nt (e.g., reduction in number of lesions, etc.)?	Y		N	1	
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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.