PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 4/21/2026
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the topical treatment of moderate to severe chronic hand eczema in an adult?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed in combination with other janus kinase (JAK) inhibitors or potent immunosuppressants?	**Y** ☐	**N** ☐
3.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
4.	Has the patient achieved or maintained a positive clinical response as evidenced by improvement [e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]?	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance of 60 grams per month?	**Y** ☐	**N** ☐
6.	Has the patient experienced an inadequate treatment response to a medium or higher potency topical corticosteroid?	**Y** ☐	**N** ☐
7.	Is a medium or higher potency topical corticosteroid NOT advisable for the patient?	**Y** ☐	**N** ☐
8.	Does the patient require MORE than the plan allowance of 60 grams per month?	**Y** ☐	**N** ☐

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.