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CAREFIRST - MD EXCHANGE 5T

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 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name:	_____	Date:	11/28/2023
Patient ID:	_____	Patient Date Of Birth:	_____
Patient Group No:	_____	Patient Phone:	_____
NPI#:	_____	Physician Name:	_____
Physician Office Address:	_____	Specialty:	_____
		Physician Office Telephone:	_____

Drug Name (select from list of drugs shown)

Rufinamide Tablets

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 adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome in a patient one year of age or older? 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

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark