CAREFIRST
Brexafemme ST with Limit Post PA

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 Brexafemme ST with Limit Post PA.

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)

Brexafemme (ibrexafungerp)

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 an adult or post-menarchal pediatric patient?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for the treatment of vulvovaginal candidiasis (VVC)?	**Y** ☐	**N** ☐
3.	Has the patient experienced an inadequate treatment response to a course of therapy with fluconazole?	**Y** ☐	**N** ☐
4.	Has the patient experienced an intolerance to fluconazole?	**Y** ☐	**N** ☐
5.	Does the patient have a contraindication that would prohibit a trial of fluconazole?	**Y** ☐	**N** ☐
6.	Is the requested drug being used in a footbath?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 4 tablets per 7 days?	**Y** ☐	**N** ☐
8.	Is the requested drug being prescribed for reduction in the incidence of recurrent vulvovaginal candidiasis (RVVC)?	**Y** ☐	**N** ☐
9.	Has the patient experienced an inadequate treatment response to a course of therapy with fluconazole?	**Y** ☐	**N** ☐
10.	Has the patient experienced an intolerance to fluconazole?	**Y** ☐	**N** ☐
11.	Does the patient have a contraindication that would prohibit a trial of fluconazole?	**Y** ☐	**N** ☐
12.	Is the requested drug being used in a footbath?	**Y** ☐	**N** ☐
13.	Does the patient require MORE than the plan allowance of 4 tablets 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

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