Prior Authorization Form

CAREFIRST

Actinic Keratosis Products

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 Actinic Keratosis Products.

Drug Name (select from list of drugs shown)

Carac (fluorouracil)	Fluorouracil Cream 0.5%	Imiquimod
Klisyri (tirbanibulin)	Tolak (fluorouracil)	Zyclara (imiquimod)

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 the diagnosis of actinic keratosis (AK)?	Y N
[If Yes, go to 2. If No, go to 4.]	
2. Is the request for continuation of therapy?	Y N
[If Yes, go to 3. If No, then no further questions.]	
3. Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., percentage of actinic keratosis lesions cleared, patient and/or prescriber satisfaction, etc.)?	Y N

	[No further questions.]	
4.	Is the request for Zyclara?	Y N
	[If Yes, go to 5. If No, then no further questions.]	
5.	Does the patient have the diagnosis of external genital warts?	Y N
	[If Yes, go to 6. If No, then no further questions.]	
6.	Is the request for continuation of therapy?	Y N
	[If Yes, go to 7. If No, then no further questions.]	
7.	Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., percentage of warts cleared)?	Y N
	[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