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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 treatment of irritable bowel syndrome with constipation (IBS-C)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is the request for a patient 7 years of age or older? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Is the requested drug being prescribed for the treatment of chronic idiopathic constipation (CIC) in an adult patient? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Is the requested drug being prescribed for the treatment of functional constipation (FC)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Is the request for a pediatric patient 6 years of age or older? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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.