Prior Authorization Form

CAREFIRST

Lodoco PA with Limit

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 Lodoco PA with Limit.

Drug Name (select from list of drugs shown)
Lodoco (colchicine)

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.	Is the requested drug being prescribed to reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death?	Y N
	[If Yes, go to 2. If No, then no further questions.]	
2.	Does the patient have established atherosclerotic disease [NOTE: Clinical atherosclerotic disease includes acute coronary syndromes, history of myocardial infarction (MI), angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral arterial disease (PAD).]?	Y N

	[If Yes, go to 4. If No, go to 3.]	
3.	Does the patient have multiple risk factors for cardiovascular disease (e.g., family history of premature atherosclerotic cardiovascular disease (ASCVD), primary hypercholesteremia, metabolic syndrome, chronic kidney disease (CKD), etc.)?	Y N
	[If Yes, go to 4. If No, then no further questions.]	
4.	Is the patient currently receiving therapy for chronic coronary disease (e.g., antiplatelet or anticoagulant, lipid-lowering agent, beta-blocker, renin-angiotensin inhibitor, etc.)?	Y N
	[If Yes, go to 5. If No, then no further questions.]	
5.	Does the patient require MORE than the plan allowance of 30 tablets per month?	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