PA Request Criteria

00-000000000

191506

CAREFIRST - MD EXCHANGE 5T
Metronidazole Topical Limit, Post PA (HMF)

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 Metronidazole Topical Limit, Post PA (HMF).

Patient Name: _____ **Date:** 11/29/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)

Metronidazole Cream Metronidazole Gel Metronidazole Lotion
Rosadan Cream (metronidazole)

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 rosacea? **Y** ☐ **N** ☐
2. Is the requested drug being used in a footbath? **Y** ☐ **N** ☐
3. Does the patient require more than the plan allowance of 120 grams or milliliters 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

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