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**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: _____
NPI#: _____	Physician Name: _____
	Specialty: _____
	Physician Office Telephone: _____
Physician Office Address: _____	

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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 2. Is the requested drug being used in a footbath? | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 3. Does the patient require more than the plan allowance of 120 grams or milliliters per month? | 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

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