

Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Pancrelipase (HMF)

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 **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Pancrelipase (HMF).

Drug Name
(specify drug) _____

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 for the treatment of exocrine pancreatic insufficiency due to cystic fibrosis, chronic pancreatitis, pancreatectomy, or other conditions?

Y N

[If Yes, then go to 2. If No, then no further questions.]

2. Is this request for Viokace (pancrelipase)?

Y N

[If Yes, then go to 3. If No, then no further questions.]

3. Will the patient take Viokace (pancrelipase) in combination with a proton pump inhibitor (PPI)?

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