Prior Authorization Form

#CAREFIRST - ITALIAN GOVERNMENT

Santyl Collagenase

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 Santyl Collagenase.

Drug Name (select from list of drugs shown)
Santyl Ointment (collagenase)

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 debriding chronic dermal ulcers or severely burned areas?	Y N
[If no, then no further questions.]	
2. Is this a renewal request?	Y N
[If no, then skip to question 4.]	
3. Has the wound been evaluated for granulation tissue?	Y N
[If no, then no further questions.]	
4. Does the patient require MORE than the plan allowance of 90 grams 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