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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 8/25/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:** _____
NPI#: _____ **Specialty:** _____
Physician Office Telephone: _____

Physician Office Address: _____

Drug Name (specify drug): _____

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 topical treatment of primary axillary hyperhidrosis? | Y ☐ | N ☐ |
| 2. Is the patient 9 years of age or older? | Y ☐ | N ☐ |
| 3. Is this request for continuation of therapy? | Y ☐ | N ☐ |
| 4. Has the patient achieved or maintained a positive clinical response to the requested drug? | Y ☐ | N ☐ |
| 5. Has the patient experienced an inadequate treatment response to a topical antiperspirant (e.g., aluminum chloride hexahydrate)? | Y ☐ | N ☐ |
| 6. Has the patient experienced an intolerance to a topical antiperspirant (e.g., aluminum chloride hexahydrate)? | Y ☐ | N ☐ |
| 7. Does the patient have a contraindication that would prohibit a trial of a topical antiperspirant (e.g., aluminum chloride hexahydrate)? | Y ☐ | N ☐ |
| 8. Is this request for Qbrexza (glycopyrronium)? | Y ☐ | N ☐ |
| 9. Does the patient require MORE than the plan allowance of 30 cloths (1 carton) per month of Qbrexza (glycopyrronium)? | Y ☐ | N ☐ |
| 10. Does the patient require MORE than the plan allowance of 50 mL (1 multi dose metered pump containing 60 actuations) per month of Sofdra (sofipironium)? | 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

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.