CAREFIRST - DC EXCHANGE 5T
Tazorac (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 Tazorac (HMF).

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Tazorac Cream 0.05% (tazarotene) Tazarotene Gel 0.1% Tazarotene Gel 0.05% Tazarotene Cream 0.1%

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of acne vulgaris?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for the treatment of plaque psoriasis?	**Y** ☐	**N** ☐
3.	Does the plaque psoriasis affect less than or equal to 20 percent of the patient's body surface area?	**Y** ☐	**N** ☐
4.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
5.	Has the patient experienced an inadequate treatment response to at least one topical corticosteroid? [Note: The patient may continue to use a corticosteroid product (e.g., clobetasol, fluocinonide, mometasone, triamcinolone, etc.).]	**Y** ☐	**N** ☐
6.	Has the patient experienced an intolerance to at least one topical corticosteroid?	**Y** ☐	**N** ☐
7.	Does the patient have a contraindication that would prohibit a trial of topical corticosteroids?	**Y** ☐	**N** ☐
8.	Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., clear or almost clear outcome, patient satisfaction, etc.)?	**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