

CAREFIRST
Veozah PA with Limit

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 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Veozah PA with Limit.

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group:	<input type="text"/>
Patient DOB:	<input type="text"/>

Physician Information

Physician Name	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Addr.:	<input type="text"/>
City, St, Zip:	<input type="text"/>

Drug Name (select from list of drugs shown)

Veozah (fezolinetant)

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 moderate to severe vasomotor symptoms due to menopause? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is this request for continuation of therapy? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Has the patient achieved or maintained a positive clinical response to the requested drug? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Has the patient been re-evaluated periodically to determine if treatment is still medically necessary? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Does the patient require MORE than the plan allowance of 30 tablets 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

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.