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	anamar far anah muantian	
	·	YN
exocrine pancreation	ug being prescribed for the treatment of insufficiency due to cystic fibrosis, pancreatectomy, or other conditions?	YIN
[If Yes, then go to	2. If No, then no further questions.]	
2. Is this request for Viokace (pancrelipase)?		YN
[If Yes, then go to	3. If No, then no further questions.]	
Will the patient take with a proton pump	e Viokace (pancrelipase) in combination inhibitor (PPI)?	YN
[No further questi	ons.]	

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