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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: 1/30/2025
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 prophylaxis or chronic treatment of asthma? Y ☐ N ☐
2. Is the patient 12 years of age or older? 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.