Prior Authorization Form

CAREFIRST

Mupirocin Limit-Post Limit

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 **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Mupirocin Limit-Post Limit.

Drug Name (select from list of drugs shown)

Centany (mupirocin ointment 2%) Centany AT Kit (mupirocin) Mupirocin Cream 2%
Mupirocin Ointment 2%

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 answer for each question.

1. Which drug is being requested (applies to brand or generic)?

[NOTE: Please check the drug being requested (applies to brand or generic).]

Mupirocin calcium CREAM (If checked, go to 2) ☐

Mupirocin OINTMENT (Centany) (If checked, go to 3) ☐

2. Is the requested drug being prescribed for the any of the following: A) treatment of secondarily infected traumatic skin lesions due to susceptible isolates of Staphylococcus Y N

	aureus or Streptococcus pyogenes, B) superficial bacterial skin infections?	
	[If Yes, then go to 4. If No, then no further questions.]	
3.	Is the requested drug being prescribed for any of the following: A) impetigo due to Staphylococcus aureus or Streptococcus pyogenes, B) superficial bacterial skin infections, C) prophylaxis of catheter exit-site infections?	Y N
	[If Yes, then go to 4. If No, then no further questions.]	
4.	Is the requested drug being used in a footbath?	Y N
	[If Yes, then no further questions. If No, then go to 5.]	
5.	Is the requested drug being prescribed to treat a body surface area that requires MORE than 30 grams in a one-month period?	Y N
	[If Yes, then go to 6. If No, then no further questions.]	
6.	Does the patient require MORE than the plan allowance of 60 grams per month?	Y N
	[No further questions.]	

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