



00-000000000



178995

CAREFIRST ASO
Fabior

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 Fabior.

Patient Name: _____	Date: 11/27/2023
Patient ID: _____	Patient Date Of Birth: _____
Patient Group No: _____	Patient Phone: _____
NPI#: _____	Physician Name: _____
	Specialty: _____
	Physician Office Telephone: _____
Physician Office Address: _____	

Drug Name (select from list of drugs shown)

Fabior (tazarotene) Tazarotene Foam

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 the diagnosis of acne vulgaris? 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.