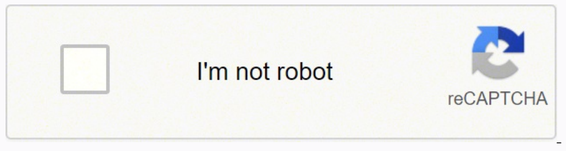

Next

Caremark speciality pharmacy prior authorization forms

CHARLOTTESVILLE DERMATOLOGY

ANNA MAGEE MD * DEBORAH ELDER MD * CHELSI MILLER NP

MINOR CHILD MEDICAL AUTHORIZATION FORM

It is the policy of Charlottesville Dermatology to have a parent or legal guardian present during a minor patient's initial visit. This helps the parent/guardian have a comprehensive understanding of your child's care and treatment options.

In the event that you, as parent or guardian cannot be present during a future visit(s) please complete the below listed authorization for the care of your child.

I, the undersigned, and parent(s) of _____, hereby authorize (name of person to accompany child)_____, to authorize any and all medical treatment for (name of minor child) _____they, in their discretion, see fit. This includes, but is not limited to examination and treatment.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until _____ ____, 2012.

MEDICAL INSURANCE COMPANY: _____

MEDICAL INSURANCE ID or GROUP #: _____

MEDICAL INSURANCE CO. PHONE #: _____

POLICY HOLDER NAME AND DOB: _____

PEDIATRICIAN/PCP NAME PHONE #: _____

_____ _____

Parent/Legal Guardian Date

CAREMARK

Care Appeal Form To Use a Brand Name Medicine

Plan Participant: Please complete Sections I and II. (Incomplete information will delay processing.)

Doctor: Please complete Section III and IV. Sign, Date, and FAX to Caremark.

Section I: Plan Participant Information – (Print Clearly)		
Name: Date of Birth: Cardholder ID #:	Address: City: State, Zip:	Day Telephone: Evening Telephone:
Section II: Doctor Information – (Print Clearly)		
Doctor Name:	Address 1: Address 2: City: State, Zip:	Telephone: Fax:
Section III: Name of generic medicine that you are appealing		
Medicine Name:	Medicine Strength:	
Dosage Form:	Diagnosis:	
Section IV: Doctor Questionnaire		
	Please circle "Yes" or "No".	
1. Patient has intolerance to the generic equivalent, e.g. adverse reaction, allergy or sensitivity	Yes	No
2. Patient failed a trial with the generic equivalent	Yes	No
3. Transition to generic may pose a clinical risk	Yes	No
4. Patient requires the use of brand name medicine (please document reason below)	Yes	No
Please describe the clinical necessity of this prescription for this patient:		
In the event we require additional clinical information, may we contact you?	Yes	No
As the patient's doctor who is prescribing the brand name product listed in this document, I certify that all the information regarding the patient's medicine history is complete and correct. Doctor Signature: _____ Date: _____		

FAX the completed form to Caremark at 1-866-399-2734. Thank you.

91-68841

CVS/caremark

Formulary Exception/Prior Authorization Request Form

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Patient ID#:					
Address:			Address:		
City:	State:		City:		State:
Home Phone:	Zip:		Office Phone #:	Office Fax #:	Zip:
Gender: M or F	DOB:		Contact Person at Doctor's Office:		
Diagnosis and Medical Information					
Medication:	Strength:			Frequency:	
Expected Length of Therapy:	Qty:	Day Supply:	If this is a continuation of therapy, how long has the patient been on the medication?		
Diagnosis:			Diagnosis (ICD) Code(s):		
FORM CANNOT BE EVALUATED WITHOUT REQUIRED CLINICAL INFORMATION					

What condition is the drug being prescribed for?

_____

_____

Please list all medications the patient has tried specific to the diagnosis and specify below:

CareFirst
Family of health care plans

CVS caremark

Zometa, zoledronic acid
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Patient's Name: ______ Date: ______
Patient's ID: ______ Patient's Date of Birth: ______
Physician's Name: ______
Specialty: ______ NPI#: ______
Physician Office Telephone: ______ Physician Office Fax: ______

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:
Patient Weight: ______ kg
Patient Height: ______ ft ______ inches

Criteria Questions:
1. What is the prescribed drug? ☐ Zometa ☐ zoledronic acid (generic) ☐ Other ______
2. What is the diagnosis?
☐ Prostate cancer
☐ Bone metastases from solid tumors (other than prostate cancer)
☐ Multiple myeloma
☐ Hypercalcemia of malignancy
☐ Other ______
3. What is the ICD-10 code? ______

Complete the following questions if patient's diagnosis is prostate cancer.

4. Does the patient have castration-recurrent prostate cancer? ☐ Yes ☐ No *If No, skip to #6*
5. Does the patient have bone metastases? ☐ Yes ☐ No *No further questions*
6. Is zoledronic acid or Zometa requested for the treatment or prevention of osteoporosis secondary to androgen-deprivation therapy (ADT)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X ______
Prescriber or Authorized Signature Date (mm/dd/yy)

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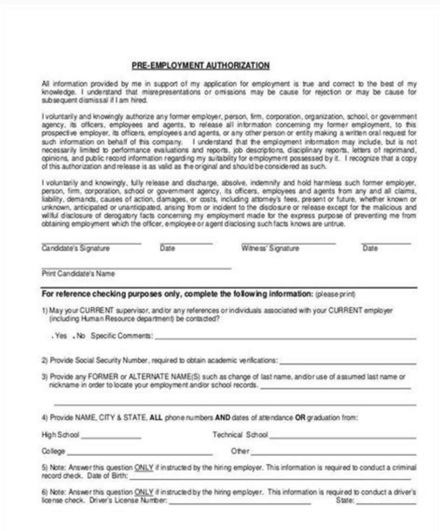

PRE-EMPLOYMENT AUTHORIZATION

Generally, Health Net will only approve a request for an exception if preferred alternative drugs or utilization restrictions would not be as effective in treating the member's condition and/or would cause the members to have harmful medical effects. Step 10 – Provide any additional relevant information. If so, provide documentation. Prior authorization - Pharmacy Some drugs require prior authorization. No phone trees. Paste medicaredeterminations@healthnet.com in the To: field. Drugs on the preferred brand tier and Specialty tier may not be eligible for an exception for payment at a lower tier. Step 1 – In "Patient Information", provide the patient's full name, ID number, full address, phone number, date of birth, and gender. Waive coverage restrictions or limits on a drug. To access Secure Messaging, you must be registered on HealthNet.com. Step 12 – On page 2, specify the type of medication requested and select yes or no in response to the questions related to each specific drug. If this is a continuation therapy, specify how long the patient has been on this medication. Our response to the request will explain if the drug is approved to be covered. No hold times. A coverage determination can also be requested by calling Customer Service. LET's GET STARTED 1 - CoverMyMeds Provider Survey, 2019 2 - Express Scripts data on file, 2019 A CVS/Caremark prior authorization form is to be used by a medical office when requesting coverage for a CVS/Caremark plan member's prescription. A fast decision is sometimes called an expedited coverage determination and applies only to requests for Part D drugs that members have not already received. We know PA requests are complex. This means that members must receive approval from Health Net before the drug will be covered. Select Compose. There are different types of exceptions that can be requested. Exceptions Members or providers can request a coverage determination to make an exception to our coverage rules. If we deny the request, members can appeal our decision. That's why we have a team of experts and a variety of help resources to make requests faster and easier. Step 11 – The prescriber must provide their signature as well as the date at the bottom of page 1. Step 4 – Next, specify the following: what condition the drug is being prescribed for, any therapeutic failure(s) (including length of therapy for each drug), contraindicated drug(s) and any adverse effects for each drug. Step 3 – In "Diagnosis and Medical Information", specify the medication, strength, frequency, expected length of therapy, quantity, and day supply. Information on how to file an appeal is included with the denial notification. Requests for a fast decision can be made by fax or by calling Customer Service. If so, provide risk factors. If you would like to view forms for a specific drug, visit the CVS/Caremark webpage, linked below. If a prescription drug is not covered, or there are coverage restrictions or limits on a drug, members or providers may request a coverage determination. Lastly, supply the diagnosis and diagnosis ICD code(s). If a request is sent by email, it must include the member's name, Health Net member ID number and telephone number, as well as the details of the request. Please note that if we grant a request to cover a drug that is not on our formulary, the drug will be available for the non-preferred brand tier copayment. Step 6 – Specify whether or not the patient has a chronic condition confirmed by diagnostic testing. We also require a supporting statement from the prescriber explaining why a particular drug is medically necessary for the member's condition. View A List Of Drugs Subject To Prior Authorization Coverage determination process To request an exception or to obtain prior authorization, members or prescribers can email, fax or mail a coverage determination request to the contact information listed below. The prior authorization process ensures members are receiving the correct drug combined with the best value for their medical condition. Send your specialty Rx and enrollment form to us electronically, or by phone or fax. An exception can be requested to: Cover a drug even if it is not on our formulary. Log in to the Secure Messaging Center. Email To protect personal health information and privacy, please do not send emails to Health Net using a personal email account. Please attach any supporting or relevant documents to your secure email message. Step 9 – Specify whether or not there are additional risk factors (e.g., GI risk, cardiovascular risk, age) present. A physician will need to fill in the form with the patient's medical information and submit it to CVS/Caremark for assessment. Contact information Phone Prescribers: 1-800-867-6564 Calls received after hours will be handled by our automated phone system and a Health Net representative will return the call on the next business day. In doing so, CVS/Caremark will be able to decide whether or not the requested prescription is included in the patient's insurance plan. The fact that a drug is listed on the formulary does not guarantee that it will be prescribed for a particular medical condition. Mail Health Net Prior Authorization Department PO Box 419069 Rancho Cordova, CA 95741-9069 Fax Commercial members: 866-399-0929 Medi-Cal members Pharmacy PA: 800-869-4325 More information For more information about coverage determinations, exceptions and prior authorization, refer to the plan's coverage documents or call Customer Service. If a drug has a quantity limit, members can ask us to waive the limit and cover more. Also, mention any anticipated significant adverse events. Step 5 – Specify whether or not the request is for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change. Step 2 – In "Prescriber Information", provide the prescriber's full name, full address, office phone number, office fax number, and supply a name of a contact person. Health Net has a Secure Messaging Center to make corresponding with us safe and efficient. Cover a drug at a lower tier. If so, provide diagnostic test and date. We will make our decision and respond to all requests as quickly as the member's health condition requires. We must make our decision regarding an exception or prior authorization request and respond no later than 72 hours (24 hours for Medi-Cal covered drugs) after we have received the prescriber's supporting statement. You will be prompted to enter an email address in the To: field. If so, provide dosage form. Standard & fast decisions If waiting up to 72 hours for a "standard" decision could seriously harm the member's health or their ability to function, members or their prescribers can ask us to make a "fast" decision. Once we receive the coverage determination request, it is reviewed to determine if it meets the requirements for approval. Step 7 – Specify whether or not the patient has a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature. For example, Health Net may limit the amount of a drug that will be covered. If a request for a fast decision is received, we must make our decision and respond within 24 hours. Step 8 – Specify whether or not the patient requires a specific dosage form (e.g., suspension, solution, injection). The drug is not eligible for an exception for payment at a lower tier.