Call CVS Caremark Prior Authorization Department: 855-240-0536

Or Fax Completed Form & applicable clinical progress notes to: 888-836-0730

Questions? Contact CVS Caremark Customer Services: 888-543-4921

Johns Hopkins EHP, c/o CVS Caremark Prior Authorization Dept.,
1300 E. Campbell Rd, Richardson, TX 75081
www.ehp.org

Prescribing Guide Formulary Exception Form

Patient Information			Prescriber Information		
Patient Name: **Patient ID#:**			Prescriber Name:		
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

PLEASE CHECK ALL BOXES THAT APPLY:

☐ What condition is the drug being prescribed for? _____

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

Reason(s) for failure, date of trial, including length of therapy for each drug:
_____

Drugs (s) contraindicated: _____

Adverse event (e.g. toxicity, allergy) for each drug:_____

☐ Is the request for a patient with one or more chronic conditions (e.gl, 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? Specify anticipated significant adverse event: _____

☐ Does the patient have a chronic condition confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____

☐ Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

☐ Other: Please provide additional relevant information: _____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

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 documentation supporting this information is available for review if requested by CVS Caremark, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____