



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare) Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)

Cyclophosphamide (Medicare B vs. D)

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 Cyclophosphamide (Medicare B vs. D).

Drug Name (select from list of drugs shown)

Cyclophosphamide tablets

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State, _____

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

1. Is this drug being used as treatment for cancer? Y N
[If the answer to this question is no, then no further questions are required.]
2. Is the oral formulation used for the same indication(s) as the Y N
formulation that cannot be self-administered?
[If the answer to this question is no, then no further questions are required.]
3. Will the oral formulation be used as a full replacement for the Y N
formulation that cannot be self-administered?

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date