



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Tetanus Inj (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 Tetanus Inj (Medicare B vs.D) .

Drug Name (select from list of drugs shown)

Tetanus Toxoid Injection

Tetanus-Diphtheria Toxoid

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 the patient receiving the tetanus vaccine as prophylaxis/treatment for wound management (such as but not limited to wounds contaminated with dirt, feces, soil and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns and frostbite)?

Y N

Comments: _____

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

Prescriber (Or Authorized) Signature and Date