



# 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) Trexall (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 Trexall (Medicare B vs. D).

**Drug Name (select from list of drugs shown)**  
Trexall

#### 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**