



**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:						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:  
 Therapeutic failure, 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.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? Specify anticipated significant adverse event: \_\_\_\_\_
- Does that 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.

PLEASE COMPLETE CORRESPONDING SECTION ON BACK PAGE FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Insomnia Agents/Proton Pump Inhibitors

Provigil/Nuvigil/Stimulants/Tazorac/Tretinoin Products/Testosterone Products/Triptans

**\*\*FOR ANY DRUG/CLASS NOT LISTED ON THE BACK PAGE, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES\*\***

**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: \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.**

**ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN**

Does the patient have secondary medical risk factors? Please specify which risk factor(s): \_\_\_\_\_

If the patient has a diagnosis of Onychomycosis, does the infection involve the toenails, fingernails or both? Please circle

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? Yes or No

**ANTIEMETIC (5-HT3) AGENTS:**

Is the patient receiving moderate to highly emetogenic chemotherapy? Yes or No

Is the patient receiving radiation therapy? Yes or No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? Yes or No

**CELEBREX:**

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed)? Yes or No

Is the patient being treated for post-operative pain following CABG surgery? Yes or No

**ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL**

Does the patient require nitrate therapy on a regular OR on an intermittent basis? Yes or No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology? Please circle.

Is it being used for Pulmonary Arterial Hypertension (PAH)? Yes or No

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)? Yes or No

**INSOMNIA AGENTS:**

Have other treatable medical/psychological causes of chronic insomnia been considered and/or addressed? Yes or No

Have appropriate sleep hygiene and sleep environment issues been addressed? Yes or No

**PROTON PUMP INHIBITORS:**

Does the patient have frequent and severe symptoms of GERD (e.g., heartburn, regurgitation)? Yes or No

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? Yes or No

Were the symptoms inadequately controlled with the histamine2-receptor antagonist (H2RA)? Yes or No

**PROVIGIL/NUVIGIL:**

Does the patient have a diagnosis of Shift Work Sleep Disorder? Yes or No

If the patient has a diagnosis of Obstructive Sleep Apnea, is the patient currently using a continuous positive airway pressure (CPAP) machine? Yes or No

**STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

Will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? Yes or No

**TAZORAC/ TRETINOIN PRODUCTS:**

Has the patient tried and failed products from the following categories: Salicylic Acid Products OR Benzoyl Peroxide products? Yes or No

**If the patient is female**, has the physician discussed with the patient the potential risks of fetal harm and importance of birth control while using Tazorac? Yes or No

Will the patient be applying Tazorac to less than 20 percent of body surface area? Yes or No

**TESTOSTERONE PRODUCTS:**

Before the start of testosterone therapy did the patient (or does the patient currently) have a confirmed low testosterone level or absence of endogenous testosterone? Yes or No

Does the patient have carcinoma of the breast or known or suspected prostate cancer? Yes or No

**TRIPTANS:**

Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? Yes or No

Is the patient currently using migraine prophylactic therapy (e.g., amitriptyline, propranolol, timolol)? Yes or No

Please submit completed form to secure fax 501-378-6980 or secure email [ManagedPharmacy@arkbluecross.com](mailto:ManagedPharmacy@arkbluecross.com).

CVS Caremark is an independent company that provides pharmacy claims processing services for Arkansas Blue Cross and Blue Shield.