Prescriber Criteria Form

Acitretin 2025 PA Fax 1459-A v1 010125.docx
Acitretin
Coverage Determination

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 **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Acitretin.

Drug Name:
Acitretin

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for any of the following: A) Lichen planus, B) Keratosis follicularis (Darier Disease), C) Prevention of non-melanoma skin cancers in a high risk individual? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of severe psoriasis? [If no, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to methotrexate or cyclosporine?	Yes	No

Comments: ____________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ **Date:**____________________