Prescriber Criteria Form
Albendazole 2025 PA Fax 5812-A v1 010125.docx
Albendazole generic only
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 Albendazole generic only.

Drug Name:
Albendazole generic only

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 the treatment of parenchymal neurocysticercosis caused by a larval form of the pork tapeworm, Taenia solium? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the treatment of cystic hydatid disease of the liver, lung, or peritoneum caused by a larval form of the dog tapeworm, Echinococcus granulosus? [If yes, then no further questions.]	Yes ◯	No ◯
3	Is the requested drug being prescribed for Microsporidiosis? [If yes, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being prescribed for any of the following: A) Ascariasis, B) Trichuriasis?	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:_____