Prescriber Criteria Form

Bronchitol 2025 PA Fax 4340-A v1 010125.docx
Bronchitol (mannitol inhalation powder)
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 Bronchitol (mannitol inhalation powder).

Drug Name:
Bronchitol (mannitol inhalation powder)

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	Does the patient have a diagnosis of cystic fibrosis? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient passed the Bronchitol Tolerance Test? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested medication be used as add-on maintenance therapy? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient 18 years of age or older?	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:**_____