Prescriber Criteria Form

Drizalma Sprinkle 2025 PA Fax 3399-A v1 010125.docx
Drizalma Sprinkle (duloxetine)
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 Drizalma Sprinkle (duloxetine).

Drug Name:
Drizalma Sprinkle (duloxetine)

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 ANY of the following: A) major depressive disorder, B) diabetic peripheral neuropathy, C) fibromyalgia, D) chronic musculoskeletal pain, E) cancer pain, F) chemotherapy-induced neuropathic pain? [If yes, then skip to question 4.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the treatment of generalized anxiety disorder? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient 7 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient tried duloxetine capsules? [If yes, then no further questions.]	Yes ◯	No ◯
5	Is the patient unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)?	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:_____