Prescriber Criteria Form
HRM Scopolamine 2025 PA Fax 3510-B v2 010125.docx
Transderm Scop (scopolamine transdermal patch extended-release)
This HRM List Applies To Formulary Drugs Only.
Prior Authorization applies only to patients 70 years of age or older.
Prior authorization applies to greater than cumulative 30 days of therapy per year.
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 Transderm Scop (scopolamine transdermal patch extended-release).

Drug Name:
Transderm Scop (scopolamine transdermal patch extended-release)

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) prevention of nausea and vomiting associated with motion sickness, B) prevention of post-operative nausea and vomiting, C) excessive salivation? [If no, then no further questions.]	Yes ◯	No ◯
2	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient?	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:**_____