Prescriber Criteria Form Megestrol 2025 PA Fax 1437-A v1 010125.docx Megestrol acetate 625mg/5mL suspension 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 Megestrol acetate 625mg/5mL suspension.

Drug Name: Megestrol acetate 625mg/5mL suspension

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 anorexia, cachexia, or an unexplained significant weight loss in a patient with a diagnosis of acquired immunodeficiency syndrome (AIDS)? [If yes, then skip to question 3.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the treatment of cancer-related cachexia in an adult? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response or intolerance to megestrol 40 milligrams per milliliter (40mg/mL) oral suspension?	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:**_____