Prescriber Criteria Form

Nebs-Pentamidine 2025 PA Fax BD-11 v1 010125.docx
Inhalation Solutions
Nebupent (pentamidine isethionate)
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 Nebupent (pentamidine isethionate).

Drug Name:
Nebupent (pentamidine isethionate)

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 patient using the requested drug with a nebulizer? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of human immunodeficiency virus (HIV) (ICD-10 diagnosis code B20), or pneumocystosis (ICD-10 diagnosis code B59), or complications of organ transplants (ICD-10 diagnosis code T86.00-T86.03, T86.09-T86.13, T86.19-T86.23, T86.290, T86.298, T86.30-T86.33,T86.39-T86.43,T86.49,T86.5, T86.810-T86.812, T86.818, T86.819, T86.830-T86.832, T86.838, T86.839, T86.850-T86.852, T86.858, T86.859, T86.890-T86.892, T86.898, T86.899, T86.90-T86.93, T86.99)?	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:**_____