Prescriber Criteria Form

Oral Chemo 2025 PA Fax BD-17 v1 010125.docx
Oral Chemotherapy Agents/Oral Immunosuppressant Agents
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 Oral Chemotherapy Agents/Oral Immunosuppressant Agents.

Drug Name:

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 Methotrexate (excluding 2.5mg tablets) or Cyclophosphamide being used as treatment for cancer? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Is the oral chemotherapy formulation being used for the same indication as the injectable chemotherapy formulation? [No further questions.]	Yes ◯	No ◯
3	Is this medication being used as a component of an immunosuppressive regimen for an organ transplant? [Tech Note: If the answer to this question is yes, please see work instructions to complete B vs D determination.]	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:**_____