Prescriber Criteria Form

Tazorac 2025 PA Fax 1462-A v1 010125.docx
Tazorac (tazarotene)
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 Tazorac (tazarotene).

Drug Name:
Tazorac (tazarotene)

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	Does the patient have a diagnosis of acne vulgaris? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for plaque psoriasis to treat less than or equal to 20 percent of the patient's body surface area? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response to at least one topical corticosteroid? [If yes, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced an intolerance to at least one topical corticosteroid? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a contraindication that would prohibit a trial of topical corticosteroids?	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:_____