

Prescriber Criteria Form

Vitamin D Topical 2025 PA Fax 2569-A v1 010125.docx

Vitamin D Analogs Topical

Calcipotriene Topical Scalp Solution, Calcitrene (calcipotriene ointment), Dovonex (calcipotriene cream), Enstilar (calcipotriene/betamethasone dipropionate foam), Sorilux (calcipotriene foam), Taclonex (calcipotriene/betamethasone dipropionate ointment, suspension), Vectical (calcitriol ointment), Wyzora (calcipotriene/betamethasone dipropionate cream)  
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 Vitamin D Analogs Topical.

Drug Name (select from list of drugs shown):

**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 psoriasis? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a topical steroid?	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:** \_\_\_\_\_