



Prior Authorization Form

Preventive Services Contraceptive Zero Copay Exception*

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 1-888-487-9257. Please contact CVS/Caremark at 1-800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Preventive Services Contraceptive Zero Copay Exception*.

Drug Name

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug medically necessary for the patient as a preventive service? [Y N]

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date