Non-Specialty Formulary Exception/Prior Authorization Request Form

Patient Information			Prescriber Information		
Patient Name:	DOB:		Prescriber Name:	NPI#	
Patient ID#:			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Office Phone #:	Secure Office Fax #:	
Home Phone:	Gender: M or F		Contact Person at Doctor's Office:		

Drug Information			
Medication and Strength:	Directions for use (Frequency):		Expected Length of Therapy:
Qty:	Day Supply:	ICD10 Code/Diagnosis:	Route of Administration:

PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION
Solely providing demographic and drug information may not constitute a sufficient request for coverage.
Specific drugs/classes are listed on page 2. For any drugs/classes not listed, please attach relevant clinical documentation.

☐ **Expedited/Urgent Review Requested:** *By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*

Continuation of Therapy:

1. Has the patient been receiving the requested drug within the last 120 days? ***Yes or No***
2. Has the requested drug been dispensed at a pharmacy and approved for coverage previously by a prior plan? ***Yes or No***
3. How long has the patient been on the requested medication?_____
4. Has the patient had a positive response to treatment or had improvement in symptoms? ***Yes or No***
5. Has the patient's need for continued therapy been assessed within the previous year? ***Yes or No***

Is the requested product being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ***Yes or No***

Does the prescribed dose/quantity fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literature? ***Yes or No***

Please list ALL medications the patient has tried specific to the diagnosis and specify below**:**

Medication _____Explanation for failure or contraindication _____
Medication _____Explanation for failure or contraindication _____
Medication _____Explanation for failure or contraindication _____
*ALL other medications tried and reasons for failure: _____

Is the request for a patient with a highly sensitive condition (e.g., psychiatric condition, epilepsy, organ transplant) who is stable on the current drug(s) and who might be at high risk for a significant adverse event or harm with a medication change? ***If yes, specify anticipated significant adverse event:***

_____

Does the patient have a chronic condition confirmed by diagnostic testing? ***If yes, please provide diagnostic test and date***: _____

Does the patient require a specific dosage form (e.g., suspension, solution, injection)? ***If yes, please provide dosage form and clinical explanation***:

_____

Does the patient have a clinical condition for which other formulary alternatives are not recommended or are contraindicated due to comorbidities or drug interactions based on published clinical literature? If so, please provide documentation including medication names and clinical reasons.

_____

Is the request for Diabetic Test Strips or Continuous Blood Glucose Monitoring System (CGM)? ***If yes, please answer the relevant questions below.***

a. Test strips: Does the patient have an insulin pump? If yes, please provide make and model (e.g., OmniPod, MiniMed 670G)_____
   Does the patient have an insulin pump that is incompatible with Accu-Chek or OneTouch product? ***Yes or No***
b. CGM: Is the patient using an intensive insulin regiment? ***Yes or No*** If for continuation of therapy, is the patient being assessed every 6 months for adherence to their CGM regimen and diabetes treatment plan? ***Yes or No*** Is the patient currently not meeting glycemic targets OR experiencing hypoglycemia? ***Yes or No***

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS.

PLEASE FAX COMPLETED FORM TO 1-833-896-0650.

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 documentation supporting this information is available for review if requested by CVS Caremark®, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____

COMPLETE CORRESPONDING SECTION FOR SPECIFIC DRUGS/CLASSES LISTED BELOW. CIRCLE THE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS:**

1. Does the patient have a diagnosis of onychomycosis due to dermatophytes (tinea unguium) confirmed by a fungal diagnostic test? ***Yes or No***
2. Is the request for treatment of tinea capitis? ***Yes or No***
3. Is the request for treatment of tinea corporis or tinea cruris in a patient who meets any of the following: has extensive disease, dermatophyte folliculitis is present, did not respond to topical therapy, or is immunocompromised? ***Yes or No***
4. Has the patient experienced an inadequate treatment response, intolerance or contraindication to an oral antifungal therapy? ***Yes or No***
5. Is the requested drug being used in a footbath? ***Yes or No***

☐ **CGRP RECEPTOR ANTAGONISTS INJ, IV/ORAL:**

1. Is the request for Aimovig, Ajovy, Emgality 120mg, or Vyepti for the preventive treatment of migraine in an adult? ***Yes or No***
2. Is the request for Nurtec ODT or Qulipta for the preventive treatment of episodic migraine in an adult? ***Yes or No***
3. Is the request for Nurtec ODT or Ubrelvy for the acute treatment of migraine in an adult? ***Yes or No***
   If yes to question 3, did the patient experience an inadequate treatment response or an intolerance to two triptan 5-HT1 receptor agonists or has a contraindication that would prohibit a trial of triptan 5-HT1 receptor agonists? ***Yes or No***
4. Has the patient had at least 3 months of treatment with the requested drug? ***Yes or No***
   If yes to question 4, has there been a reduction in migraine days per month from baseline? ***Yes or No***
5. Did the patient experience an inadequate treatment response with an 8-week trial, an intolerance or has a contraindication that would prohibit an 8-week trial of any of the following: A) Antiepileptic drugs (AEDs), B) Beta-adrenergic blocking agents, C) Antidepressants? ***Yes or No***
6. Is the request for Emgality 100mg for treatment of episodic cluster headaches in an adult? ***Yes or No***
7. Has the patient received at least 3 weeks treatment with Emgality 100mg? ***Yes or No***
   If yes to question 7, has there been a reduction in weekly cluster headache attack frequency from baseline? ***Yes or No***
8. Did the patient have an inadequate treatment response, intolerance, or contraindication to sumatriptan (subcutaneous or nasal) or zolmitriptan (nasal or oral)? ***Yes or No***
9. Will the drug not be used concurrently with another CGRP receptor antagonist? ***Yes or No***

☐ **ERECTILE DYSFUNCTION:**

1. Is the drug being prescribed for erectile dysfunction, symptomatic Benign Prostatic Hyperplasia (BPH), or other diagnosis? ***Circle appropriate diagnosis***

☐ **PROVIGIL/NUVIGIL:**

1. Does the patient have a diagnosis of Shift Work Disorder (SWD)? ***Yes or No***
   If yes to question 1, has a sleep log and actigraphy monitoring been done for at least 14 days and shows a disrupted sleep and wake pattern? ***Yes or No***
   If yes to question 1, have the symptoms been present for 3 or more months? ***Yes or No***
2. Does the patient have a diagnosis of Obstructive Sleep Apnea confirmed by polysomnography? ***Yes or No***
   If yes to question 2, is the patient been receiving treatment for the underlying airway obstruction (continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BIPAP]) for at least one month? ***Yes or No***
3. Does the patient have a diagnosis of Narcolepsy confirmed by sleep lab evaluation? ***Yes or No***
4. Is the drug being prescribed by, or in consultation with, a sleep specialist? ***Yes or No***
5. Is the drug being prescribed for idiopathic hypersomnia?
6. Is the request for Provigil, and is the drug being prescribed for multiple sclerosis-related fatigue? ***Yes or No***

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

1. Does the patient have a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? ***Yes or No***
2. Has the diagnosis been documented (e.g., complete clinical assessment, using DSM-5®, standardized rating scales, interviews/questionnaires)? ***Yes or No***
3. Does the patient have a diagnosis of narcolepsy confirmed by sleep study? ***Yes or No***
4. Is the request for Vyvanse and does the patient have a diagnosis of moderate to severe binge eating disorder (BED)? ***Yes or No***
5. Is the request for a methylphenidate product which is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out? ***Yes or No***
6. If patient is 5 years of age or younger, do they continue to have ADHD/ADD symptoms despite participating in evidence-based behavioral therapy? ***Yes or No***
7. Is the request for Strattera and will the patient be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior? ***Yes or No***

☐ **TRETINOIN PRODUCTS:**

1. Does the patient have the diagnosis of acne vulgaris or keratosis follicularis (Darier's disease, Darier-White disease)? ***Yes or No***

☐ **TESTOSTERONE PRODUCTS:**

1. Does the patient have primary or hypogonadotropic hypogonadism? ***Yes or No***
2. Does the patient have age-related hypogonadism? ***Yes or No***
3. Does the patient have at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values? ***Yes or No***
4. Is the drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy? ***Yes or No***

☐ **VOLTAREN GEL:**

1. Does the patient have osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists or elbows? ***Yes or No***
2. Is treatment with Voltaren necessary due to concern about intolerance or a contraindication to oral nonsteroidal anti-inflammatory (NSAID) drugs? ***Yes or No***