2/2/2017

Prior Authorization Form

UMWA FUNDS

Brand over Generic Medical Necessity*

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 Brand over Generic Medical Necessity*.

Drug Name (select from list of drugs shown)

Other, Please specify

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 a renewal authorization being requested for the branded medication? Y N
   [If the answer to this question is no, then skip to question 5.]
2. Has the patient been re-challenged on the generic agent(s)? Y N
   [If the answer to this question is no, then skip to question 4.]
3. Did the patient experience an adverse event with the generic agent(s) re-challenge (e.g., rash, nausea, vomiting)? Y N
   [No further questions are required.]
4. Does the prescriber feel the patient can safely be re-challenged on the generic agent(s)? Y N
   [No further questions are required.]
5. Has the patient had a trial of the generic agent(s)? Y N
6. Did the patient fail an adequate trial (e.g., 30 days) of the generic agent(s)? Y N
7. Was the failure due to an adverse event experienced with the Y N

generic agent(s) (e.g., rash, nausea, vomiting)?

8. Is the adverse event attributable to the inactive ingredients of the generic agent(s) and not the active ingredient? Y N
9. Was the adverse event documented in the chart of the patient? Y N
10. Was the adverse event documented on the MedWatch Form 3500? Y N

    (Note: MedWatch form can be obtained from http://www.fda.gov/downloads/Safety/MedWatch/Howtoreport/downloadforms/ucm082727.pdf or 1-800-FDA-1088.)
11. Was the MedWatch form filed with the FDA? Y N

    (Note: Filing of the MedWatch form is required for benefit override consideration.)

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date