5/7/2020

Prior Authorization Form

Internal Use Only

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 no, then skip to question 5.]

2. Has the patient been re-challenged on the generic agent(s)? Y N

[If no, then skip to question 4.]

3.	Did the patient experience an adverse event with the generic agent(s) re-challenge? (e.g., rash, anaphylaxis)	Y N
	[No further questions.]	
4.	Does the prescriber feel the patient can safely be re-challenged on the generic agent(s)?	Y N
	[No further questions.]	
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 generic agent(s)? (e.g., rash, anaphylaxis)	Y N
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
	[NOTE: The Funds requests that the adverse event is documented on the MedWatch Form 3500. Please refer to https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program/reporting-serious-problems-fda or call 1-800-FDA-1088]	

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