Arkansas BlueCross BlueShield
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Octave BlueCross BlueShield
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BlueAdvantage Administrators of Arkansas
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Health Advantage
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Arkansas Pharmacy Formulary Exception/Prior Approval Request Form

Pharmacy Drug Benefit Only

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 1-855-245-2134 for prior approval, step therapy, and quantity limit requests**. Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior approval, step therapy, and quantity limit review process.

For Non-Formulary Exception requests, fax the form to **501-378-6980**. For Non-Formulary request questions, contact **501-378-3392**.

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

Medication Requesting and Diagnosis			
Medication:	Strength:		Directions for use (Frequency):
Expected Length of Therapy:	Qty:	Day Supply:	If this is a continuation of therapy, how long has the patient been on the medication?
Diagnosis:		Diagnosis (ICD) Code(s):	

PLEASE ATTACH ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION WITH REQUEST

☐ **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.***

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

Medication Name	Trial period	Reason for Failure
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○

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 a patient with one or more chronic conditions (e.g., psychiatric condition, epilepsy, dementia) who is stable on the current drug(s) and who might be at high risk for a significant adverse event 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***: _____

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

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