CAREMARK
PRIOR AUTHORIZATION FORM REQUEST

Please complete and fax this form to Caremark at 888-836-0730 to request a Drug Specific Prior Authorization Form. Once we receive your request, we will fax you a Drug Specific Prior Authorization Request Form along with the patient's specific information and questions that must be answered. When you fax the Drug Specific Prior Authorization Request Form to us, we will review it and notify you and the patient of the result. If we deny your request, we will also provide you and the patient with the denial reason.

SECTION I: PATIENT INFORMATION

Last Name, First Name (PLEASE PRINT)	Date of Birth (MM/DD/YYYY)
Street Address	Phone Number ( )
City	State
Cardholder ID #	ZIP Code

SECTION II: DRUG INFORMATION

Drug Name (PLEASE PRINT)	Drug Strength

SECTION III: PRESCRIBER INFORMATION

Prescriber's Name (PLEASE PRINT)	
Prescriber's Address (Street, City, State, ZIP code)	
Prescriber's Phone Number ( )	Prescriber's Fax Number ( )

Incomplete or illegible forms and missing fields will delay the processing of your request. Please complete all fields to ensure appropriate processing.