Prior Authorization Form

CLEVELAND-CLIFFS STEEL LLC

Brand Penalty Exception*

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 Penalty Exception*.

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. Has the patient experienced an inadequate treatment response (tried and failed) with the generic equivalent (not including other generic alternatives in the same therapeutic class) of the requested brand drug?	Y N
[If yes, then no further questions.]	
2. Has the prescriber determined that the generic equivalent (not including other generic alternatives in the same therapeutic class) of the requested brand drug is not	Y N

	appropriate based on a specific clinical concern (e.g. allergy)?	
	[If yes, then no further questions.]	
3.	Has the patient been stabilized on a brand name medication for a specific clinical condition (e.g. fragile epilepsy, transplant immunosuppression, etc.)?	Y N

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

Prescriber (Or Authorized) Signature and Date