CVS CAREMARK

Specialty Pharmacy 1-800-237-2767

TOTAL HEALTH CARE

CatalystRx®

Drug Authorization Request Form

COMPLETE AND FAX TO CAREMARK CONNECT 1-800-323-2445

PHYSICIAN INFORMATION			
Name of person completing this form		Date Faxed	
Physician Name		Physician Specialty	
Phone Number		Fax Number	
NPI or DEA #		Pharmacy Fax	

MEMBER INFORMATION			
First Name		Last Name	
Plan	TOTAL HEALTH CARE		
Member ID		Date of Birth	

Part 2:

Drug requested and directions for use (e.g. mg/day)	Diagnosis:

Is patient currently taking drug (yes, no)? ____________________ If yes, for how long? ____________________________________

Other drugs previously tried:

Name of drug, dose and date **Outcome** (reason why it failed or wasn't tolerated)

____ ____

____ ____

____ ____

Other reason(s) why this particular drug was selected *(attach chart notes, pertinent laboratory tests or procedures and results, letter or supporting literature as appropriate)*

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: ___________________________ Proposed duration of therapy: ______________

Strength/Quantity: ___________________________ Daily dose: ___________________ Height: ____________ Weight: __________

Sig. ____

☐ Supplies package (no charge): sharps disposal unit (regular or large), alcohol wipes (100 per box), syringes as necessary

Prescriber's Name ____ Date ______________________________

Print Name

Signature ____