Prior Authorization Form for Texas Medicaid
Global Prescription Exceptions (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Caremark at 1-866-255-7569. Please contact Caremark at 1-877-440-3621 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Global Prescription Exceptions.

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Drug Name: ________________________________

Patient Information

Patient Name: ________________________________
Patient ID: ________________________________
Patient Group Number: ________________________________
Patient Date of Birth: ________________________________

Prescribing Physician

Physician Name: ________________________________
Physician Phone: ________________________________
Physician Fax: ________________________________
Physician Address: ________________________________

City, State ZIP: ________________________________

Diagnosis: ________________________________ ICD Code: ________________________________

Please circle the appropriate answer for each question.

1. If this is an office-administered injectable drug...
   A. Is your intent to provide and bill for this medication? OR  
   B. Is your intent to have it provided through a pharmacy?  
   Y N

2. Is the requested drug being used for an FDA-approved indication?  
   Y N
   [If the answer to this question is yes, then skip to Question 4.]

3. Is the requested drug being used for an indication that is supported by information from the appropriate compendia of current literature (e.g., AHFS, Micromedex, current accepted guidelines, etc.)?  
   Y N

4. Has the patient demonstrated a failure of or intolerance to a majority (not more than three) of the preferred formulary or preferred drug list alternatives for the given diagnosis?  
   Y N

5. Is the drug being prescribed within the manufacturer's published dosing guidelines, or does it fall within dosing guidelines found in the compendia of current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)?  
   Y N

6. Is the drug being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program?  
   Y N

Comments: ________________________________

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

Prescriber (or authorized) Signature and Date

PF-TX-0003-12 March 2012