Prior Authorization Form

HMSA ASO

Rapid Acting Insulin

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 **1-855-762-5207**.
Please contact CVS/Caremark at **1-855-240-0543** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Rapid Acting Insulin.

Drug Name (select from list of drugs shown)

Afrezza (insulin inhalation powder, human recomb)	Apidra (insulin glulisine)	Humalog (insulin lispro)

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. If this is a renewal request, is there medical record documentation supporting clinical response to the medication? Y N

[If yes, then no further questions.]

2. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? Drug Name and Reason for Failure. Y N _____

Formulary alternative is: Novolog

	[If yes, then no further questions.]
3.	Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed? Reason(s) the patient cannot try the formulary alternatives. Y N
	Formulary alternative is: Novolog

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

Prescriber (Or Authorized) Signature and Date