Prescriber Criteria Form Cequr 2026 PA Fax 6793-A v1 010126.docx Cequr Simplicity Coverage Determination
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 **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cequr Simplicity.

Drug Name: Cequr Simplicity

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is this a request for continuation of therapy with an insulin pump? [If yes, then no further questions.]	Yes	No
2	Does the patient have diabetes requiring insulin management? [If no, then no further questions.]	Yes	No
3	Does the patient meet one of the following: A) currently self-testing glucose levels, B) will be counseled on self-testing glucose levels, C) using a continuous glucose monitor? [If no, then no further questions.]	Yes	No
4	Has the patient tried bolus insulin injections? [If no, then skip to question 6.]	Yes	No
5	Does the patient meet either of the following: A) did not meet glycemic goals, B) had difficulty administering multiple insulin injections daily? [No further questions.]	Yes	No
6	Is the patient unable to try bolus insulin injections?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____