Prescriber Criteria Form
RSV Vaccine 2026 PA Fax 6734-A v1 010126.docx
RSV Vaccine
Abrysvo (respiratory syncytial virus vaccine), Arexvy (respiratory syncytial virus vaccine recombinant), Mresvia (respiratory syncytial virus vaccine suspension)
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 RSV Vaccine.

Drug Name (select from list of drugs shown):

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 the requested drug being used for the prevention of lower respiratory tract disease (LRTD) and severe lower tract respiratory disease (LRTD) caused by respiratory syncytial virus (RSV)? [If no, then no further questions.]	Yes	No
2	Has the patient previously received a respiratory syncytial virus (RSV) vaccine (i.e., Abrysvo, Arexvy, Mresvia)?	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:**_____