| Prescriber Criteria Form<br>Rabies Vacc 2026 PA Fax BD-23 v1 010126.docx<br>Rabies Vaccines<br>Imovax, Rabavert<br>Coverage Determination |
|---|
| This fax machine is located in a secure location as required by HIPAA regulations.<br>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 Rabies Vaccines. |

| 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 rabies vaccine being prescribed as a preventative vaccine for a patient who is at risk of exposure to rabies?<br>(Note: Post-exposure prophylaxis is not eligible for coverage under Part D.) | 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:**_____ |