

Prescriber Criteria Form
Tetanus Vacc 2026 PA Fax BD-19 v1 010126.docx
Tetanus Vaccines
Tetanus Toxoid (TT), Tetanus Diphtheria Toxoid (Td)
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 Tetanus 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 patient receiving the tetanus vaccine as a routine booster (not related to injury or illness)?	Yes	No
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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:** _____