Prescriber Criteria Form

Vitamin D Topical 2026 PA Fax 2569-A v1 010126.docx
Vitamin D Analogs Topical
Calcipotriene Topical Scalp Solution, Calcitrene (calcipotriene ointment), Dovonex (calcipotriene cream), Enstilar (calcipotriene/betamethasone dipropionate foam), Sorilux (calcipotriene foam), Taclonex (calcipotriene/betamethasone dipropionate ointment, suspension), Vectical (calcitriol ointment), Wynzora (calcipotriene/betamethasone dipropionate cream)
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 Vitamin D Analogs Topical.

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 prescribed for the treatment of psoriasis? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to a topical steroid?	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:**_____