CAREFIRST
Emverm Post Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Emverm Post Limit.

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Drug Name (select from list of drugs shown)

Albendazole
Albenza Tablets (albendazole)
Biltricide Tablets (praziquantel)
Egaten (triclabendazole)
Emverm (mebendazole)
Praziquantel

Quantity: ____________ **Frequency:** __________________ **Strength:** __________________

Route of Administration: _______________________ **Expected Length of Therapy:** _____________________

Diagnosis: ________________________________ **ICD Code:** ________________________________

Comments: ____
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Please check the appropriate answer for each applicable question.

1. Has the infection been confirmed by a diagnostic or laboratory test (e.g. imaging scans, blood, stool, or urine test)? **Y** ☐ **N** ☐

2. Is this request for mebendazole (Emverm) in a patient 2 years of age or older for any of the following: A) Ancylostoma duodenale (hookworm), B) Ascaris lumbricoides (roundworm), C) Enterobius vermicularis (pinworm), D) Necator americanus (hookworm), E) Trichuris trichiura (whipworm). **Y** ☐ **N** ☐

3. Does the patient require a second course of therapy (first course of therapy administered within the past year) at a dose up to 2 tablets per day for two 3 day treatments? **Y** ☐ **N** ☐

4. Is this request for albendazole (Albenza) for the treatment of Hydatid Disease? **Y** ☐ **N** ☐

5. Does the patient require a second course of therapy (first course of therapy administered within the past year) at a dose up to 4 tablets per day for three 28-day cycles with 14-day free intervals? **Y** ☐ **N** ☐

6. Is this request for praziquantel (Biltricide) in a patient 1 year of age or older for the treatment of any of the following: A) Schistosomiasis, B) Clonorchiasis, C) Opisthorchiasis? **Y** ☐ **N** ☐

7. Does the patient require a quantity up to 36 tablets per treatment course OR a second day or course of therapy (first course of therapy administered within the past year)? **Y** ☐ **N** ☐

8. Is the request for triclabendazole (Egaten) in a patient that is 6 years of age or older for the treatment of fascioliases? **Y** ☐ **N** ☐

9. Does the patient require a quantity up to 32 tablets per treatment course OR a second course of therapy (first course of therapy administered within the past year)? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date

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