Prior Authorization Form

Relenza Post Limit

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Relenza Post Limit.

Drug Name (select from list of drugs shown)
Relenza (zanamivir)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.	
1. Is this request for Xofluza (baloxavir)?	Y N
[If no, then skip to question 3.]	
2. Is this request for a patient 12 years of age or older who has acute uncomplicated influenza?	Y N
[If yes, then skip to question 10.]	
[If no, then no further questions.]	
3. Is the requested drug being prescribed for the prophylaxis (prevention) or the treatment of influenza A or B viral infection?	Y N

4.	Is this request for oseltamivir (Tamiflu) for prophylaxis in a patient 3 months of age or older who has been exposed to a community outbreak?	Y N
	[If no, then skip to question 8.]	
5.	Does the patient require more than the following quantities for 6 weeks: A) 42 capsules of 75mg or 45mg, B) 84 capsules of 30mg, C) 540mL/9bottles of suspension?	Y N
	[If no, then no further questions.]	
6.	Is this request for a patient with immune deficiencies?	Y N
	[If no, then no further questions.]	
7.	Does the patient require more than the following quantities for 12 weeks: A) 84 capsules of 75mg or 45mg, B) 168 capsules of 30mg, C) 1080mL/18 bottles of suspension?	Y N
	[No further questions.]	
8.	Is this request for Relenza (zanamivir) for prophylaxis in a patient 5 years of age or older who has been exposed to a community outbreak?	Y N
	[If no, then skip to question 10.]	
9.	Does the patient require more than 60 blisters (30 doses)?	Y N
	[No further questions.]	
10.	Is this request for more than any of the following for this course of therapy: A) Tamiflu (oseltamivir): 10 capsules of 75mg or 45mg; 20 capsules of 30mg; 180mL/3 bottles of suspension, B) Relenza (zanamivir): 20 blisters, C) Xofluza (baloxavir): 2 tablets of 20mg or 40mg?	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.

Prescriber (Or Authorized) Signature and Date