Prescriber Criteria Form

Xermelo 2024 PA Fax 1671-A v1 010124.docx
Xermelo (telotristat ethyl)
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 Xermelo (telotristat ethyl).

Drug Name:
Xermelo (telotristat ethyl)

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 carcinoid syndrome diarrhea? [If no, then no further questions.]	Yes	No
2	Is the patient's diarrhea inadequately controlled by somatostatin analog therapy? [If no, then no further questions.]	Yes	No
3	Will the requested drug be used in combination with somatostatin analog therapy?	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:**____________________