CAREMARK
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Care Appeal Form To Use a Brand Name Medicine

Plan Participant: Please complete Sections I and II. (Incomplete information will delay processing.)

Doctor: Please complete Section III and IV. Sign, Date, and FAX to Caremark.

Section I: Plan Participant Information – (Print Clearly)		
Name: Date of Birth Cardholder ID #:	Address: City: State, Zip:	Day Telephone: Evening Telephone:
Section II: Doctor Information – (Print Clearly)		
Doctor Name:	Address 1: Address 2: City: State, Zip:	Telephone: Fax:

Section III: Name of generic medicine that you are appealing	
Medicine Name:	Medicine Strength:
Dosage Form:	Diagnosis:

Section IV: Doctor Questionnaire

		Please circle "Yes" or "No".	
1.	Patient has intolerance to the generic equivalent, e.g. adverse reaction, allergy or sensitivity.	Yes	No
2.	Patient failed a trial with the generic equivalent	Yes	No
3.	Transition to generic may pose a clinical risk	Yes	No
4.	Patient requires the use of brand name medicine (please document reason below)	Yes	No

Please describe the clinical necessity of this prescription for this patient:

In the event we require additional clinical information, may we contact you?	Yes	No

As the patient's doctor who is prescribing the brand name product listed in this document, I certify that all the information regarding the patient's medicine history is complete and correct.

Doctor Signature:_____ Date: _____

FAX the completed form to Caremark at 1-866-309-2734. Thank you.

91-005481