

# Drug Coverage Review Request

## Tazarotene Cream

35045



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder's ID# \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Medco manages the prescription drug benefit for your patient at the request of their plan sponsor. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

### SECTION A Please answer the following questions

For which use is tazarotene (Tazorac) being prescribed?

Acne       Psoriasis       Other condition (specify) \_\_\_\_\_  
\_\_\_\_\_

### SECTION B Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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