Prescriber Criteria Form Ivermectin Tab 2024 PA Fax 4922-A v1 010124.docx Stromectol (ivermectin tab) 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 Stromectol (ivermectin tab).

Drug Name: Stromectol (ivermectin tab)

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 prevention or treatment of coronavirus disease 2019 (COVID-19)? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for treatment of any of the following: A) Strongyloidiasis of the intestinal tract, B) Onchocerciasis, C) Ascariasis, D) Cutaneous larva migrans, E) Mansonelliasis, F) Scabies, G) Gnathostomiasis, H) Pediculosis?	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:**_____