Insurance Management Services, Inc.
RX/Prescription Pre-Determination request
eMail: CVSPRED@imsm.net or Fax to: (806) 373-1458

If the member has received a RX rejection notice from CVS/Caremark for the prescribed medication, please have the provider complete/submit the following:

Request Date: _____ Faxed By: _____ Phone: _____

Patient Name: _____ DOB: _____

Insured Name: _____ SS# of Insured: _____

Employer: _____ Group#: _____

Prescriber Information: (PLEASE PRINT)

First Name/Last Name: _____ ☐ MD ☐ DO ☐ NP/PA

_____

Address City ST Zip

Phone: _____ **Fax:** _____ **Email:** _____

Tax ID: _____ **Office Contact Name:** _____

Product Information: ☐ **Brand** ☐ **Generic or equivalent**

_____

Full RX Medication Name **Dose/Frequency** **Route** **Duration of Treatment**

Place of Administration:

☐ **Self-administered** ☐ **Physician Office** ☐ **Infusion Center** ☐ **Home Infusion**

Diagnosis:

_____ **ICD 9/ICD 10 Code:** _____

_____ **ICD 9/ICD 10 Code:** _____

Clinical Substantiation:

_____

_____

_____

Please attach & fax any other documentation to support the medical necessity for the requested prescribed medication (i.e., current progress notes, copies of diagnostic studies, other supporting documentation) along with this request to CVSPreD@imsm.net or Fax 806-373-1458.

For follow up please contact 1-800-687-3020.