

Gardasil / Cervarix (HPV vaccine)



Prior Authorization Request (Physician to Complete)

An Independent Licensee of the Blue Cross and Blue Shield Association

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____ Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: _____

Thank you for taking the time to provide clinical information to ensure appropriate drug therapy for your patient. Please answer the following questions and fax this form back to (866) 884-4345.

1. Which HPV vaccine are you requesting?

- Gardasil
- Cervarix

2. Is the patient female?

- Yes
- No

3. What is the patient's age? _____ years

4. Has the patient started the Gardasil/Cervarix vaccine series already?

- Yes, at what age? _____ years
- No

3. Directions: _____

4. Additional Comments: _____

Refer to the Wellmark Drug List on www.wellmark.com for current medication tier levels

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Printed Name

Signature

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