**Delaware Medicaid Drug Coverage Request Form**

**Instructions:** Use this form to ask us to cover a drug that we would not usually cover or would restrict in some way. Please fill out ALL REQUIRED FIELDS of this form. Submit the request by sending the completed form to Pharmacy Services by fax @ 1-844-233-6130 OR complete electronically at https://www.covermymeds.com/main/prior-authorization-forms. To see a list of the drugs we cover and rules we have about coverage, please visit https://www.delawarefirsthealth.com/providers/pharmacy.html.

If you need help filling out this form, ask your doctor or call us at the number on the back of your member ID card.

**Who is making this request? Provider  Member  Appointed Representative**

***Appointed Representatives*:** Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete the following section ONLY if the person making this request is not the member or prescriber:

|  |  |  |
| --- | --- | --- |
| Requestor’s Name | | |
| Requestor’s Relationship to Member | | |
| Address | | |
| City | State | Zip Code |
| Requestor Phone | | |

**Representation documentation for requests made by someone other than member or the member’s prescriber:**

**Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan.**

**\*REQUIRED FIELDS – ONE MEDICATION PER FORM.**

|  |  |  |
| --- | --- | --- |
| \*Member Name: | | |
| \*Member ID #: | \*Date of Birth: | |
| Member Phone: | \*Duration (how long therapy lasts):  **Indefinite?**  **YES**  **NO**  *If the box above is left blank, it will be assumed that the request is indefinite.* | |
| \*Drug Name/Strength/Form (e.g., tablet, capsule): | \*Quantity Prescribed: | Day Supply: |
| \*Frequency (i.e., how often, how many): | |
| \***Generic Substitution Permitted:**  **YES**  **NO**  *If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the \*Drug Name field.* | | |
| \*Associated Diagnosis: *list all diagnoses and ICD-10 codes being treated with the drug.* | | |
| \*Submitting Provider NPI: | \*Provider Name (First Name & Last Name): | |
| \*Provider Mailing Address (including city, state, ZIP): | | |
| Provider Phone: | Provider Fax: | |
| \*Office Contact Name: | \*Provider Signature: | |
| Pharmacy Name: | Pharmacy Phone: | |
| \*Drug Allergies: | | |
| **DRUG HISTORY:** (for treatment of the condition(s) requiring the requested drug) | | |
| **Drugs Tried:** if quantity limit is an issue, list unit dose/total daily dose tried | **RESULTS of previous drug trials. Indicate FAILURE vs. INTOLERANCE** (explain) | |
|  |  | |
|  |  | |
|  |  | |
| What is the member’s current drug regimen for the condition(s) requiring the requested drug? | | |

**Reasons for Your Request.** Use the space below and attach additional pages, if needed. **A supporting statement from your doctor is required.** Attach any information that supports your request, such as a statement from your doctor and relevant medical records.