Prior Authorization Request Form for Prescription Drugs

The covermymeds portal is the preferred way to receive prior authorization requests. Please access the covermymeds portal to complete your prior authorizations quickly and accurately. This is a free service. **Alternatively, you may fax this completed form to 844-233-6130.**

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information. Requests for prior authorization (PA) must be completed in entirety. **Incomplete forms will delay processing.**

To support the request based on medical necessity, appropriate clinical information must be submitted. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.).

I. PROVIDER INFORMATION	**II. MEMBER INFORMATION**
Prescriber Name (printed):	Member Name:
Office Contact Name:	Identification Number:
Group name:	Group Number:
Fax:	Date of Birth:
Phone:	Medication Allergies:

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:

Diagnosis relevant to this request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?

☐ Yes; How Long? [If yes, go to section B]

☐ No [If no, skip sections B & C]

B. Is this request for continuation of a previous approval?

☐ Yes [if yes, go to section C]

☐ No [If no, go to section D]

C. Has strength, dosage, or quantity required per day increased or decreased?

☐ Yes [Go to section D]

☐ No [Skip to section D; Indicate rationale for continuation in Section IV]

D. Please indicate previous treatment and outcomes below.		
Drug Name (Include strength and dosage)	**Therapy Dates**	**Reason for Discontinuation**
1		
2		
3		
4		
NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The formulary is available on the health plan website.		
IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all prior authorizations)		
Provider Signature:		Date: