delaware first health

General Specialty Prescription Medication Prior Authorization Form

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.**

Today's Date: Date Medication Required:

Ship to: ☐ Physician ☐ Patient's Home ☐ Other:

PATIENT INFORMATION			
Last Name:	First Name:	Middle Initial:	DOB:
Address:	City:	State:	Zip Code:
Primary Phone #:	Alternate Phone #:	Gender: ☐ Male ☐ Female	

INSURANCE INFORMATION [Please attach copies of cards]	
Primary Insurance: ID# City: State:	Secondary Insurance: ID# City: State:

PHYSICIAN INFORMATION		
Name:	Specialty:	NPI:
Address:	City:	Zip Code:
Phone#:	Secure Fax#:	Office Contact Name:

PRESCRIPTION INFORMATION				
Medication(s)	Strength(s)	Directions	Quantity	Refills

PRIMARY DIAGNOSIS
Primary ICD-10 Code: Description:

CLINICAL INFORMATION

Therapy Start Date:

☐ Initial Therapy ☐ Continuation of Therapy

Patient's Weight: (in kg)	Patient's Height (in inches)

Is the member currently treated with this medication? ☐ Yes ☐ No

If continuation of therapy, how long has the patient been on treatment?

Years Months

Has the patient had a positive outcome? ☐ Yes ☐ No

Please indicate previous treatment and outcomes using the table below:

Drug Name(s) [Include strengths and dosage]	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		
5.		

NOTE: Prior use of preferred drugs is part of the exception criteria. Confirmation of use will be made from member history on file

Required for all Prior Authorizations:

Please state rationale for request and pertinent clinical information. Please use the space below as needed and attach all supporting clinical documentation with your submission.

Physician Signature:	Date:	☐ Dispense as Written?