## PRIOR AUTHORIZATION REQUEST FORM



Prior authorization or exception requests may be submitted electronically using CoverMyMeds or using the electronic health record (where available). For more information visit www.allumaco.com/providers. This form should be used only when electronic means of submission are not available.

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name	Prescriber Name
Date of Birth	Prescriber NPI Specialty
Insurance ID #	Name of Office Contact
Daytime Phone #	Phone #
Primary Care Physician	Secure Office Fax #
MEDICATION AND DIAGNOSIS INFORMATION	
Medication Strength	Directions
Anticipated Duration of Treatment O Continuous Limited (specify)	Quantity Day Supply
Diagnosis	ICD-10 Diagnosis Code(s)
MEDICATION HISTORY	
Please indicate whether this request is:	Routine Expedited/Urgent* review requested
*Urgent requests are those for medical conditions that could seriously jeopardize the life or health of the patient, the ability of the patient to regain maximum function, or which involve a medical condition that would subject the patient to severe pain that cannot be managed adequately without care or treatment.	
	O Prior Authorization
Please indicate whether you are requesting (select only one):	Affordable Care Act Coverage Exception Quantity Limit Exception
Please confirm the fill history for this specific medication:	New Start/Initial Fill Renewal/Continuation of Therapy
If this is a renewal/continuation of therapy, indicate when the	e medication was started:
List any previous medications the patient has tried and/or failed and the reason for the request:	
CLINICAL DOCUMENTATION SUPPORTING THE DIAGNOSIS, PLAN OF CARE, AND PREVIOUSLY TRIED AND FAILED THERAPIES IS REQUIRED FOR REVIEW. PLEASE INCLUDE THIS DOCUMENTATION AS AN ATTACHMENT TO YOUR REQUEST. ADDITIONAL COMMENTS	
SIGNATURE C I attest the information provided is accurate to the best of my knowledge as docume	OF PRESCRIBER ented on this form and in the attached clinical notes. I understand that the Health
Plan or its designees may perform a routine audit and request the medical information	
Prescriber Signature	Date
	INFORMATION
Fax to: (833) 951-1683 OR	Mail to: Alluma
	Attn: Clinical Department
	PO Box 14651 St. Louis, MO 63166

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