PRIOR AUTHORIZATION FORM
PHYSICIAN FAX FORM

DO NOT COPY FORMS FOR FUTURE USE – FORMS ARE UPDATED FREQUENTLY
PLEASE SUBMIT ALL RELEVANT CHART NOTES AND LABORATORY RESULTS FOR CONSIDERATION

Member Information (required)			**Prescriber Information (required)**		
Member Name:			Prescriber Name:		
Member/Insurance ID:			NPI:		
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
☐ Check if requesting **brand**	Directions for Use:	
☐ Check if request is for **continuation of therapy**	Qty:	DS:
☐ Check if request is **urgent**	☐ Check to request **priority review**	

Clinical Information (required)

What is the patient's diagnosis?

ICD-10 Code(s): _____

Is the request for initial or continuing therapy?

☐ **Initial Therapy** ☐ **Continuing Therapy**

INITIAL THERAPY

What medication(s) has the patient tried and failed? Please include medication names, dates of therapy (MM/YY), and patient's response to therapy

CONTINUING THERAPY

Is the patient responding to the current therapy and experiencing benefit (e.g., improvement in symptoms, improvement in QOL, etc.)?
☐ **Yes** ☐ **No**

Date patient started therapy (MM/YY): _____

QTY LIMIT REQUESTS

What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations? **Select all that apply –**
☐ Titration or loading dose purposes (please include specific titration/loading dose schedule and anticipate duration)
☐ Dose-alternating schedule
☐ Requested strength/dose is not commercially available
☐ Other: _____

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Are there other comments or information the prescriber wishes to provide for this review?

_____

_____

_____

Please note: Recent chart notes discussing the patient's diagnosis AND all pertinent lab values or medical tests should be included for review.

This request may be denied unless all required information is received.

Please fax completed form and supporting documentation to 1-888-473-7875

You can also access this form and submit prior authorizations electronically through CoverMyMeds - visit covermymeds.com to use this free service