## 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 In	Prescriber Information (required)			
Member Name:			Prescriber Name	Prescriber Name:			
Member/Insurance ID:			NPI:	NPI:			
Date of Birth:			Office Phone:	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	Zip:	Office Street Add	Office Street Address:			
Phone:		City:	State:		Zip:		
Medication Info	ormation (r	equired)					
Medication Name:			Strength:		Dosage Form:		
Check if requestin	ng brand	Directions for Us	Directions for Use:				
□ Check if request is for <b>continuation of therapy</b>			Qty:		DS:		
□ Check if request is <b>urgent</b>			Check to requ	Check to request priority review			
<b>Clinical Inform</b>	ation (requ	ired)					
What is the patient's diagnosis? ICD-10 Code(s):							
Is the request for initi	ial or continuing	therapy?					
Initial Therapy	-	🗆 Co	ntinuing Therapy				
INITIAL THERAP	Y						
What medication(s) h response to therapy	has the patient tr	ied and failed? Please	e include medication na	ames, dates of the	apy (MM/Y)	Y), and patient's	
CONTINUING THERAPY							
Is the patient respond <b>Yes No</b>		nt therapy and experie	encing benefit (e.g., imp	provement in symp	otoms, impro	ovement in QOL, etc.)?	
Date patient started t	herapy (MM/YY	):					
<ul> <li>Titration or loadin</li> <li>Dose-alternating</li> <li>Requested streng</li> </ul>	requested per D or exceeding the g dose purpose schedule gth/dose is not c	plan limitations? Sele	ific titration/loading dos	se schedule and ar	nticipate dur	ration)	

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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

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