ACA Contraceptive Coverage Exception

PHYSICIAN FAX FORM

ACA COVERAGE REQUESTS CANNOT BE PROCESSED WITHOUT A PRESCRIBER'S SUPPORTING STATEMENT

Member Information (required)

Member Name: _____

Member/Insurance ID: _____

Date of Birth: / /

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Prescriber Information (required)

Prescriber Name: _____

NPI: _____

Office Phone: _____

Office Fax: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Prescriber's Signature: _____ Date: / /

Medication Information (required)

Medication Name: _____ Strength: _____ Dosage Form: _____

☐ Check if request is for **brand**

Directions for Use: _____

☐ Check if request is for **continuation of therapy**

Qty: _____ DS: _____

Supporting Information for an ACA Coverage Request

Diagnosis and Medical Information

What is the patient's diagnosis?: _____ ICD-10 Code(s): _____

Is the request for initial or continuing therapy? ☐ **Initial Therapy** ☐ **Continuing Therapy**

Drug History

DRUGS TRIED	DATES OF DRUG TRIALS	REASON(S) FOR DISCONTINUATION (please explain)

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Rationale for Request

- ☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure**
  [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- ☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change**
  A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.
- ☐ **Medical need for different dosage form and/or higher dosage**
  [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]
- ☐ **Request for formulary tier exception**
  Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- ☐ **Prescriber attests medically necessary**
  Prescriber attests that the medication being prescribed is medically necessary for the participant and covered alternatives would be inappropriate
- ☐ **Other** (explain below)

Required Explanation:

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.