

# 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)

Member Name: \_\_\_\_\_  
Member/Insurance ID: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

### Prescriber Information (required)

Prescriber Name: \_\_\_\_\_  
NPI: \_\_\_\_\_  
Office Phone: \_\_\_\_\_  
Office Fax: \_\_\_\_\_  
Office Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Medication Information (required)

Medication Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Dosage Form: \_\_\_\_\_  
Check if request is for **brand**  
Check if request is for **continuation of therapy**  
Check if request is **urgent**  
Directions for Use: \_\_\_\_\_  
Qty: \_\_\_\_\_ DS: \_\_\_\_\_  
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): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Quantity 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](http://covermymeds.com) to use this free service

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