Prior Authorization Form

PHYSICIAN FAX FORM

wellDyne Better Begins Today

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 to use this free service