Medication Prior Authorization Request

Instructions:

1. Only one medication per form.
2. All fields must be completed and legible for review.
3. Prior Authorizations cannot be submitted over the phone. You can fax this form to: 877-355-8070. To submit *electronically*, go to: https://www.covermymeds.com/main/prior-authorization-forms/

Date of Request:	
Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name and Specialty:
Member ID #:	NPI #:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Plan Name:	Contact Person:
Patient Phone:	

Requestor Information	
Requestor Name:	
Relationship to Member*:	Phone:
Email Address:	

***If the requester is not the Member or a Prescriber, attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent. We also accept copies of legal documents recognized by the state or other legal documentation showing authority). For more information on appointing a representative, you may contact your plan.**

Diagnosis and Medical Information			
Medication:		Strength & Route of Administration:	
Urgency:	Frequency:	Expected Length of Therapy:	
Quantity:	Day Supply:	Height & Weight:	
BMI:	Date Calculated:	Blood Pressure:	Date Calculated:
Service Type: ☐ Retail ☐ Home Infusion			
Diagnosis Related to Medication Request:		Vacation Fill:	
Drug Allergies:		Early Refill:	

Rationale for Prior Authorization	
History of a medical condition, allergies or other pertinent information requiring the use of this medication: _____ _____ _____ Previous use of non-authorized and prior authorized medications tried and failed for this condition: Name of medication and reason for failure: _____	
You must include all necessary clinical documentation, office notes and all related laboratory results to ensure a complete PA review.	
Prescriber's Signature:	Date: