



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.covermyeds.com/main/prior-authorization-forms/>

Date of Request:			
Patient Information		Prescriber Information	
Patient Name:		Prescriber Name and Specialty:	
Member ID #:		NPI #:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Retail <input type="checkbox"/> Home Infusion			
Diagnosis Related to Medication Request:		Vacation Fill:	
Drug Allergies:		Early Refill:	

FORM08 MI

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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:

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