Prior Authorization Request Form

Save time and complete online at https://www.covermymeds.com/main/prior-authorization-forms/

CoverMyMeds provides real time approvals for select drugs, faster decisions and saves you valuable time!

Or return completed fax to [**1-833-546-1507]**

I. PROVIDER INFORMATION	**II. MEMBER INFORMATION**	
Name:	Name:	
NPI #:	Member ID:	
Office Contact:	Date of Birth:	
Phone:	Height:	Weight:
Fax:	Medication Allergies:	
Diagnosis:	ICD-10:	

III. DRUG INFORMATION	
Drug name and strength:	Dosage Form:
Directions:	Qty. per day:
Length of Therapy:	Expedite/Urgent? ☐ Yes ☐ No

IV. MEDICATION HISTORY	
A. Therapy Status: ☐ Initial ☐ Continuation	If continuation, provide therapy start date:
B. Has strength or daily dose changed? ☐ Yes ☐ No	List Change:
C. Have you attached test results (HbA1c, genetic testing, etc.) to support this request? ☐ Yes ☐ No	

V. ALTERNATIVE/CONJUNCTIVE TREATMENT HISTORY RELATED FOR THIS REQUEST

Drug Name, Strength, Form, and Dosage	**Date(s) of Therapy**	**Reason for Discontinuation (If active, please indicate)**
1.		
2.		
3.		
4.		

NOTE: Must provide medical record evidence indicating prior use of preferred drug(s).

VI. DOCUMENT CLINICAL RATIONALE FOR USE OF MEDICATION

Prescriber Signature:	Date:

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.