PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST/STEP THERAPY EXCEPTION FORM

Contains Confidential Patient Information

Complete form and fax back accordingly:

State:

Connecticut - 844-474-3350| **Georgia -** 844-512-9002|
|**Indiana -** 844-521-6940| **Kentucky -** 844-521-6947| **Maine -** 844-474-3351| **Missouri -** 844-534-9053| |**Nevada -** 844-534-9054| **New York -** 844-474-3356| **Ohio -** 844-534-9055|
|**Wisconsin -** 844-534-9056|**Virginia -** 844-474-3358|

Exchange:

Connecticut - 844-474-6220| **Georgia -** 844-512-9003|
|**Indiana -** 844-471-7938| **Kentucky -** 844-471-7939| **Maine -** 844-474-6221| **Missouri -** 844-471-7940| |**Nevada -** 844-471-7941| **New York -** 844-474-6226| **Ohio -** 844-471-7942|
|**Wisconsin -** 844-474-3340|**Virginia -** 844-474-6227|

Plan Specific:

COVA - 844-474-6218

Patient Name:	Member ID#:

	Standard		**Urgent**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		State:	Zip Code:	
Date of Birth:	☐Male ☐Female	Height (in/cm):_____Weight (lb/kg):_____		Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance Information					
Primary Insurance Name:		Patient ID Number:			
Secondary Insurance Name:		Patient ID Number:			

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Patient Name:	Member ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Prescriber Information			
First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):	Office Contact Person:		
NPI Number (individual):	Phone Number:		
DEA Number (if required):	Fax Number (in HIPAA compliant area):		
Email Address:			

Medication / Medical and Dispensing Information

Medication Name (list all that apply):

☐New Therapy ☐Renewal ☐Step Therapy Exception

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

☐Copay review (provide details): _____

☐Maine: Proactive Non-formulary request (provide start date):_____

How did the patient receive the medication?

☐Paid under Insurance

Insurance Name:_____Prior Auth Number (if known): _____

☐Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:_____

Administration Location:

☐ Patient's Home ☐ Ambulatory Infusion Center

☐ Physician's Office ☐ Long Term Care

☐ Home Care Agency ☐ Outpatient Hospital Care

☐ Other (explain): _____

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Contains Confidential Patient Information

Patient Name:	Member ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications forthis condition? **YES (if yes, complete below)** **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-9/ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the preferred drug. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws.

Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____