



## PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST 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#:
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**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:	<input type="checkbox"/> Male <input type="checkbox"/> 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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**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):			
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____			
<input type="checkbox"/> Copay review (provide details): _____ <input type="checkbox"/> Maine: Proactive Non-formulary request (provide start date): _____			
How did the patient receive the medication?			
<input type="checkbox"/> Paid under Insurance Insurance Name: _____ Prior Auth Number (if known): _____			
<input type="checkbox"/> Other (explain): _____			
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:
Administration:			
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____			
Administration Location:			
<input type="checkbox"/> Patient's Home <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's Office <input type="checkbox"/> Long Term Care <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Outpatient Hospital Care <input type="checkbox"/> Other (explain): _____			

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1. Has the patient tried any other medications for this condition?		YES (if yes, complete below)	NO
<b>Medication/Therapy</b> (Specify Drug Name and Dosage)	<b>Duration of Therapy</b> (Specify Dates)	<b>Response/Reason for Failure/Allergy</b>	
2. List Diagnoses:		ICD-9/ICD-10:	
<b>3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.</b>			
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			
<b>Attestation:</b> 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.			
<b>Prescriber Signature:</b> _____		<b>Date:</b> _____	
<b>Confidentiality Notice:</b> The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) to arrange for the return of these documents.			