Prior Authorization Request Form for Miscellaneous Medications

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Is the member currently treated with this medications?
- ☐ Yes; How long/start date? _____
- ☐ No

Does the member have any contraindications to the prescribed medication?	☐ Yes ☐ No	*Submit documentation.*
All potential drug interactions have been addressed by the prescriber such as discontinuation or dose reduction of interacting medication or counseling the member about the risks associated with the use of both interacting medications.	☐ Yes ☐ No	*Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred medication in the requested class? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		
4		

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. different agent/dose in same class from the agent being requested):
- ☐ Member is transitioned from one agent to another with the intent of discontinuing one of the medications;
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

Quantity Limit:
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

REQUEST FOR INITIAL THERAPY:

- ☐ If not prescribed by, is the requested medication prescribed in consultation with a specialist:_____
- ☐ If applicable, what measures have been taken to minimize any risk associated with the black box warning:_____
- ☐ If the request is for a combination product or alternative dosage form/strength of existing drugs, medical justification to support inability to use the individual components concurrently or preferred alternative dosage forms, strengths, or cannot be used instead:_____
- ☐ Please specify any other appropriate clinical information to support the use of the requested medication on the basis of medical necessity:_____

REQUESTS FOR CONTINUATION OF THERAPY:

- ☐ Documentation of tolerability and has experienced a positive clinical response to requested medication evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)