

Prior Authorization Request Form for Antihypertensives, Sympatholytic

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 #:		
NPI:		Group #:		
Office Contact Name:		Date of Birth:		
Fax #:		Medication Allergies:		
Phone #:				
III. DRUG INFORMATION (One drug	request per form	1)		
Drug name and strength:	Dosage Interval (sig	g):	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:				
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antihypertensives, Sympatholytic? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.				
☐ 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 RENEWAL REQUESTS: Rationale for continued use of requestions.				
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :				
Appropriate clinical information to suppor basis of medical necessity must be submitt		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.)