



Prior Authorization Request Form for Bladder Relaxant Preparation

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)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (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 Bladder Relaxants? <i>Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Taken Previously (start and end date and dose): _____ _____ _____	
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. another bladder relaxant or dose different from the agent being requested): <ul style="list-style-type: none"> <input type="checkbox"/> For a urinary antispasmodic bladder preparation, is being titrated to or tapered from another relaxant to another urinary antispasmodic bladder preparation <input type="checkbox"/> For a urinary beta-3 agonist bladder preparation, is being titrated to or tapered from another relaxant to another urinary beta-3 agonist bladder preparation <input type="checkbox"/> Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines-supporting evidence: _____ 			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
RENEWAL REQUESTS: <input type="checkbox"/> Documentation of tolerability and experienced a positive clinical response to requested medication evident 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.)