COPAY WAIVER
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. To submit this form electronically, please go to covermymeds.com.

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis (ICD code and description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, when was treatment with the requested agent started? _____
2. Is there information provided stating that the requested agent is medically necessary? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. Is the requested agent a brand product with an available formulary generic equivalent? ☐ Yes ☐ No
   If yes, has the patient tried and had an inadequate response to one or more available formulary generic equivalent to the requested agent? ☐ Yes ☐ No
   If yes, please specify: _____
   If no, does the patient have an intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
   If no, does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

Please fax or mail this form to:
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TOLL FREE
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