



Prior Authorization (Pharmacy Benefit) Request Form (Page 1 of 2)

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This form may be faxed to 803-462-5000. You can also use CoverMyMeds to submit prior authorization requests, saving you time and often delivering real-time determinations. Visit the member's health plan website to begin using this free service.

Member Information (required)				Provider Information (required)		
Member Name:				Provider Name:		
Insurance ID Number:				NPI Number:		Specialty:
Date of Birth:		Phone:		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	ZIP:		City:	State:	ZIP:
Medication Information (required)						
Medication Name:				Strength:		Dosage Form:
				Directions for Use:		
Clinical Information (required)						
What is the patient's diagnosis for the medication being requested?						
ICD-10 Code(s): _____						
What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication[s]/strengths tried, length of trial and reason for discontinuation of each medication.)						
What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication[s] with the associated contraindication or specific issues resulting in intolerance to each medication.)						
Are there any supporting labs or test results? (Please specify.)						
Quantity Limit Requests:						
What is the quantity requested per day? _____						
What is the reason for exceeding the plan limitations?						
<input type="checkbox"/> Plan limitations are exceeded for titration or loading dose purposes. <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime). <input type="checkbox"/> Requested strength/dose is not commercially available. <input type="checkbox"/> Patient requires a greater quantity for the treatment of a larger surface area (topical applications only). <input type="checkbox"/> Other: _____						

Information on this form is accurate as of this date:

Prescriber's Signature:	Date:
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received.**

For more information about the prior authorization process, please contact us at 833-494-2987 Monday – Friday from 8:30 a.m. – 5 p.m. Eastern time.

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