Prescription Drugs Prior Authorization Request Form

CoverMyMeds is the preferred way to receive prior authorization requests. Visit account.covermymeds.com to begin using this free service.

OR Call 1.833.491.0418 **OR** FAX this completed form to 1.844.205.3384

OR Mail requests to: Pharmacy Services PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber name (print):	Member name:
Prescriber NPI:	Identification number:
Office contact name:	Group number:
Group name:	Date of Birth:
Fax:	Medication allergies:
Phone:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:

Diagnosis relevant to this request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?

❑ yes; How Long?_____[go to item B] ❑no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?

❑yes [go to item C] ❑no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?

❑ yes [go to item D] ❑no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

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

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The YouthCare Health*Choice* Illinois Formulary is available on the YouthCare website at **www.ilyouthcare.com/providers/pharmacy.html** under the Preferred Drug List (PDL) link.

IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

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

Pharmacy Services will respond via fax or phone within 24 hours of receipt.

Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

For additional questions, call the Pharmacy Help Desk: 1.833.491.0418