coordinated care

Phone: 1-866-716-5099
Fax: (833) 645-2734 or complete online at CoverMyMeds.com

General Specialty Medication PA Form

Prior Authorization Form/ Prescription

Date:_____Date Medication Required: _____
Ship to: Physician Patient's Home ☐ Other_____

Patient Information

Last Name: First Name: Middle: DOB: / /

Address: City: State: Zip:

Daytime Phone: Evening Phone: Sex: Male Female

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name: Specialty: NPI:

Address: City: State: Zip:

Phone # : Secure Fax #: Office contact:

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Primary Diagnosis

Primary ICD-9/ICD-10 Code:

Description in words:

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date:

Patient's weight_____kg Patient's height _____ inches

1. Is the member currently treated with this medication? ☐ Yes ☐ No
2. If continuation of therapy, how long has the patient been on treatment?_____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐ Yes ☐ No
4. Please indicate previous treatment and outcomes?

Note: This form is to be used to request review for Specialty Medication where there is no drug specific form. For non-specialty medication, please use Preferred Drug List (PDL)/Non-Formulary Prior Auth Request Form.

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 part of the exception criteria		

5. Please state Rationale for Request / Pertinent Clinical Information (**Required for all prior authorizations**)

Physician's Signature_____**Date:**

☐ DAW

Revised 05/2022