

General Specialty Medication PA Form Prior Authorization Form/ Prescription

Phone: 1-866-716-5099

Fax: (833) 645-2734 or complete online at CoverMyMeds.com

Date:	Da	ate Medication Required:				
Ship to:	Physician	Patient's Home	Other			

Patient Informatio	n								
ast Name:	F	irst Name:		Middle:		DOB:		/ /	
Address:				City:			State	:	Zip:
Daytime Phone:			EveningPhon	e:			Sex:	Male	Female
Insurance Informa	ation (Attach Copi	es of cards	5)						
Primary Insurance:				Secondary Insura	nce:				
ID#		Group#		ID#			Group	#	
City:		State:		City:			Stat	e:	
Physician Informat	tion								
Name:				Specialty:			NPI	:	
Address:				City:			State	:	Zip:
Phone#:		e Fax #:			Offic	e contact	:		
Prescription Inform				DIRECTIONS			011	ANTIT	V DEFILI
MEDICATION	STRENGTH			DIRECTIONS			Qυ	ANTIT	Y REFILL
Primary Diagnosis									
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Primary ICD-9/ICD-									
Description in word									
Description in word Clinical Information		**** Pleas	e submit suppo	rting clinical docu	mentation*	****			
·	on *			rting clinical docu					
Clinical Information	on *		ATION OF TH		y start date				
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Physician's Signature______Date: