

Prior Authorization Request Form

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Or return completed fax to 1.866.399.0929

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Name:		Name:	
NPI #:		Member ID:	
Office Contact:		Date of Birth:	
Phone:		Height:	Weight:
Fax:		Medication Allergies:	
Diagnosis:		ICD-10:	
Is member new to the health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date of enrollment:		Request Status: <input type="checkbox"/> Initial <input type="checkbox"/> Continuation If continuation, provide date of initiation:	
III. DRUG INFORMATION			
Drug name and strength:		Dosage Form:	
Directions:		Qty. per day:	
Length of Therapy:		Expedite/Urgent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IV. MEDICATION HISTORY			
A. Is member currently being treated on this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No			Start Date:
B. Has the member previously obtained PA approval from EPS? <input type="checkbox"/> Yes <input type="checkbox"/> No			Start Date:
C. Has strength or daily dose changed? <input type="checkbox"/> Yes <input type="checkbox"/> No			List Change:
D. Have you attached test results (HbA1c, polysomnography, genetic testing, etc.) to support this request? <input type="checkbox"/> Yes <input type="checkbox"/> No			
V. ALTERNATIVE/CONJUNCTIVE TREATMENT HISTORY RELATED FOR THIS REQUEST			
Drug Name, Strength, Form, and Dosage	Date of Therapy	Reason for Discontinuation (If active, please indicate)	
1.			
2.			
3.			
4.			
NOTE: Must provide medical record evidence indicating prior use of preferred drug(s). Coordinated Care Preferred Drug List (PDL) is available on the Coordinated Care website at www.coordinatedcarehealth.com			
VI. DOCUMENT CLINICAL RATIONALE FOR USE OF MEDICATION			
Prescriber Signature:			Date:
I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.			

Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720. Envolve Pharmacy Solutions will respond within 24 hours via mail, phone, or fax upon receipt of necessary documentation. **Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents