coordinated care

envolve Pharmacy Solutions

Prior Authorization Request Form

Save time and complete online CoverMyMeds.com

CoverMyMeds provides real time approvals for select drugs, faster decisions and saves you valuable time!

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? ☐ Yes ☐ No If yes, please provide date of enrollment:	**Request Status:** ☐ Initial ☐ 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?** ☐ Yes ☐ No

IV. MEDICATION HISTORY	
A. Is member currently being treated on this medication? ☐ Yes ☐ No	**Start Date:**
B. Has the member previously obtained PA approval from EPS? ☐ Yes ☐ No	**Start Date:**
C. Has strength or daily dose changed? ☐ Yes ☐ No	**List Change:**
D. Have you attached test results (HbA1c, polysomnography, genetic testing, etc.) to support this request? ☐ Yes ☐ 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.