PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUGS

FAX this completed form to (800) 977-4170

OR Complete Electronically at https://www.covermymeds.com/main/prior-authorization-forms/

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

I. Provider Information	II. Member Information
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

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 Ambetter Formulary is available on the Ambetter Health website at www.ambetterhealth.com (search for your state to view your specific formulary document.)

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 and Ambetter Health will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends or holidays. Requests for prior authorization (PA) requests must include member name, 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.)