



PRIOR AUTHORIZATION MEDICATION – GENERAL REQUEST FORM

Coverage Policy: For medications that require prior authorization, when the only information required is a diagnosis, and previous treatment trials and failures. When requesting a medication that requires additional, more specific information (clinical notes, lab values, test results, etc) please use the prior authorization form specific to that medication (eg: Byetta, Procrit, testosterone, TZDs).*

Requests meeting the following criteria will be considered:

- Use for an FDA-approved indication
 - Intolerability or failure to other medications used to treat the stated diagnosis, after an adequate trial
- * A listing of all drugs that require prior authorization can be found at www.cvty.com.

PLEASE SEND COMPLETED FORM TO COVENTRY HEALTH CARE – PHARMACEUTICAL SERVICES

FAX: Q3 (877) 554-9139 PHONE: (877) 215-4098

Requesting Physician:	Office Contact:
Call Center ID: Tax ID Number:	Plan ID: Benefit:
Office Fax Number:	Phone Number:
Office Address:	

MEMBER INFORMATION

Patient Name:	DOB:
Member ID#:	Date of Request:

MEDICATION INFORMATION

1.	Drug Requested: <div style="display: flex; justify-content: space-between;"> Dose: Duration: </div>												
2.	Diagnosis:												
3.	List other formulary agents tried: (include all office notes and supporting documentation) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Drug: _____</td> <td style="width: 33%;">Date(s) used: _____</td> <td style="width: 33%;">Outcome: _____</td> </tr> <tr> <td>Drug: _____</td> <td>Date(s) used: _____</td> <td>Outcome: _____</td> </tr> <tr> <td>Drug: _____</td> <td>Date(s) used: _____</td> <td>Outcome: _____</td> </tr> <tr> <td>Drug: _____</td> <td>Date(s) used: _____</td> <td>Outcome: _____</td> </tr> </table>	Drug: _____	Date(s) used: _____	Outcome: _____	Drug: _____	Date(s) used: _____	Outcome: _____	Drug: _____	Date(s) used: _____	Outcome: _____	Drug: _____	Date(s) used: _____	Outcome: _____
Drug: _____	Date(s) used: _____	Outcome: _____											
Drug: _____	Date(s) used: _____	Outcome: _____											
Drug: _____	Date(s) used: _____	Outcome: _____											
Drug: _____	Date(s) used: _____	Outcome: _____											
4.	Other supporting information: (Supporting clinical documentation is particularly important when requesting an <u>exception</u> to coverage criteria for reasons of medical necessity.)												

Physician’s Signature:

CHCH 2025-2 (03/08)

Visit our Website at WWW.CVTY.COM

Fax Confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the attached material is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error please notify us immediately by telephone at 1-877-215-4100.