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:** **Dose:** **Duration:**
2.	**Diagnosis:**
3.	**List other formulary agents tried:** ***(include all office notes and supporting documentation)*** **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 exception to coverage criteria for reasons of medical necessity.)***
Physician's Signature:	

CHCH 2025-2 (03/08)

Visit our Website at WWW.CVTY.COM