Advantra® from Coventry Health Care

First Health® Part D from Coventry Health Care

GENERAL PRIOR AUTHORIZATION FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

Patient Name:	**Member ID #**
****Member Phone Number****	
Date of Request:	**DOB:**
Plan ID:	**Benefit:**
Requesting Physician:	**DEA #**
Office Phone #	**Office Fax #**
Office Address:	
Tax ID Number:	

MEDICATION INFORMATION

1. Drug Requested: ***(Please include: dose/frequency/length of therapy.)***

2. If Injectable medication, where is it being administered?
☐ Home (self-administered) ☐ Office administered

3. Diagnosis: ***(Please include all office notes supporting diagnosis.)***

4. ❑ **All covered Part D drugs on any tier of the Plan's formulary would not be as effective for the enrollee as the requested formulary drug and/ or would likely have adverse effects for the enrollee.**

❑ **The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.**

❑ **The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.**

5. Previous agents tried: ***(Include all office notes and supporting documentation.)***

Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:

6. Other Supporting information:

Physician's Signature:

Physician's Specialty:

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For Urgent Requests please call (800) 551-2694

Visit our Websites at http://www.firsthealthpartd.com, http://www.chcadvantra.com, http://www.summithealthplan.com and http://www.vistahealthplan.com