Advantra from Coventry Health Care

First Health Part D from Coventry Health Care

PRIOR AUTHORIZATION FORM

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

******Please note any information that is incomplete or illegible will delay the review process.******

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

Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:
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5. Other Supporting information:

This section to be used only if requesting an exception to the plan's utilization management requirements.
Not completing below means medical exception to the utilization requirement(s) is not needed.
☐ I have reviewed the requirements and acknowledge that the patient does not meet the plan's specific utilization requirements. However, based upon the reason I will provide below, it is my clinical opinion that my patient should be exempt from meeting the plan's clinical coverage criteria for this medication. **Statement should include specifically which requirement is not met**

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

and why patient should be exempt from meeting this requirement. **(Please note any information that is incomplete or illegible will delay the review process.)** _____ _____ _____ _____
Physician's Signature:
Physician's Specialty:

CHCH 2007-1(9/12)

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