



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: (877) 554-9137

PHONE: (877) 215-4100

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) <div style="display: flex; justify-content: space-between;"> Drug: _____ Date(s) used: _____ Outcome: _____ </div> <div style="display: flex; justify-content: space-between;"> Drug: _____ Date(s) used: _____ Outcome: _____ </div> <div style="display: flex; justify-content: space-between;"> Drug: _____ Date(s) used: _____ Outcome: _____ </div> <div style="display: flex; justify-content: space-between;"> Drug: _____ Date(s) used: _____ Outcome: _____ </div>
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 2025-3 (04/10)

Visit our Website at WWW.CVTY.COM

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