COVENTRY
Health Care

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:** _____ **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 2025-3 (04/10)

Visit our Website at WWW.CVTY.COM