General Specialty Prescription Medication Prior Authorization Form

delaware first health

CoverMyMeds is the preferred way to receive prior authorization requests.
Visit https://www.covermymeds.com/main/prior-authorization-forms to begin using this free service.
OR FAX this completed form to 833.582.2342
OR Mail requests to: Pharmacy Services PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach copies of cards.)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Primary Diagnosis

Primary ICD-10 Code: _____

Description in words: _____

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY** Therapy start date: _____

Patient's weight _____ kg Patient's height _____ inches

1. Is the member currently treated with this medication? ☐ Yes ☐ No
2. If continuation of therapy, how long has the patient been on treatment? _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐ Yes ☐ No
4. Please indicate previous treatment and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria.

5. Please state Rationale for Request / Pertinent Clinical Information (**Required for all prior authorizations.**)

Physician's Signature _____ **Date:** _____ ☐ DAW