Please complete ALL information below and fax your request to 1-888-671-5285

Cost Share Exception Policy for Preventative Medications and Women's Preventive Services under the PPACA Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

For branded products (or authorized generics), answer the following:

Has the patient had inadequate response to or inability to tolerate the generic equivalent, if available? ❑ **Yes** ❑ **No**

If **yes**, please specify: _____

Has the patient had inadequate response to or inability to tolerate a generic alternative? ❑ **Yes** ❑ **No**

If **yes**, please specify: _____

Has the prescriber provided documentation indicating the requested product is medically necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.