



Prior Authorization Request

Brand Contraceptive Copay Waiver

Patient Information

Patient Name: _____
ID #: _____
DOB: ____/____/____

Provider Information

Name: _____
Address: _____

Phone: (____) _____ - _____
Drug Requested: _____

Please answer the following questions:

- Yes No Is the requested contraceptive medically necessary because the preferred contraceptives are inappropriate for this patient?
- Yes No Is the medical necessity attested to above for the specific non-preferred contraceptive drug supported by medical record documentation?

Signature of Physician

Signature of Physician: _____ Date: ____/____/____

Complete form and fax to 844-462-5169 . Please do not include a cover sheet.

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