



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:

1. Yes No Is this non-formulary contraceptive medically necessary because the preferred contraceptives are inappropriate for this patient?
2. 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. Please do not include a cover sheet.

State:

Connecticut - 844-474-3350 | **Georgia** - 844-512-9002 |
Indiana - 844-521-6940 | **Kentucky** - 844-521-6947 | **Maine** - 844-474-3351 | **Missouri** - 844-534-9053 |
Nevada - 844-534-9054 | **New York** - 844-474-3356 | **Ohio** - 844-534-9055 |
Wisconsin - 844-534-9056 | **Virginia** - 844-474-3358 |

Exchange:

Connecticut - 844-474-6220 | **Georgia** - 844-512-9003 |
Indiana - 844-471-7938 | **Kentucky** - 844-471-7939 | **Maine** - 844-474-6221 | **Missouri** - 844-471-7940 |
Nevada - 844-471-7941 | **New York** - 844-474-6226 | **Ohio** - 844-471-7942 |
Wisconsin - 844-474-3340 | **Virginia** - 844-474-6227 |

Plan Specific:

COVA - 844-474-6218

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