carelon Rx

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