Prescription Drugs Prior Authorization Request Form

CoverMyMeds is the preferred way to receive prior authorization requests.

Visit **account.covermymeds.com** to use this free service.

OR Mail requests to: Pharmacy Services PA Department, 1 Campus Martius, Suite 750, Detroit, MI 48226

OR Call 1-855-580-1688 | **OR** FAX this completed form to 1-855-580-1695

I. PROVIDER INFORMATION	**II. MEMBER INFORMATION**
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:
Diagnosis relevant to this request:			
Expected length of therapy:			

Medication History for this Diagnosis

A. Is member currently treated on this medication?

❑ yes, How Long?_____[go to item B] ❑no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?

❑ yes [go to item C] ❑no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?

❑ yes [go to item D] ❑no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below

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 a part of the exception criteria. The Meridian Illinois Formulary is available on the Meridian website at **https://www.ilmeridian.com/providers/pharmacy.html** under the formulary link.

IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

Appropriate clinical information to support the request based on medical necessity must be submitted	Provider Signature:	Date:

Pharmacy Services will respond via fax or phone within 24 hours of receipt. Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.) For additional questions, call the **Pharmacy Help Desk: 1-855-580-1688**