Care1st Health Plan of Arizona: Pharmacy Prior Authorization Request form

Phone: 602-778-1800 (Options 5, 5) Fax: 602-778-8387

Or submit via CoverMyMeds at https://www.covermymeds.com/main/prior-authorization-forms/

INSTRUCTIONS: Please fill out all ***Required Information** completely and legibly. Attach any additional documentation that is important for the review to support the prior authorization request. (Chart notes, Lab results, Diagnostic tests, etc.)

PRIORITY			
	◯ **Routine**	◯ **Retroactive**	

◯ **Expedite/Urgent: By checking AND signing below, I certify that applying the standard of review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.**

Signature of Prescriber or Prescriber's Designee

PATIENT INFORMATION		
***Last Name:**		***First Name:**
***DOB:**	***SEX: M / F**	Phone:
Address:	City:	State/ZIP Code:

INSURANCE INFORMATION (Care1st ID is Required)	
***Care1st Health Plan (AHCCCS) ID#:**	
Other Coverage (If applicable):	ID:

PHARMACY INFORMATION		
Name:	Phone:	Fax:

PRESCRIBER INFORMATION		
***First Name:**	***Last Name:**	
***Specialty:**	***Phone:**	***Fax:**
Address:	City/State:	ZIP Code:
NPI#:	DEA#	***Office Contact:**

REQUESTED MEDICATION INFORMATION		
***Drug Requested:**	***Strength:**	***Quantity:**
***Directions** *(or provide copy of RX)**:*	Generic Substitution permitted: Y / N	
***Formulation:** *(tablet, capsule, lotion, injection, etc)*		
Refills:	New Therapy: Y / N	Duration of Therapy:
***Diagnosis (ICD-10):**		

Pharmacy Department

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***DRUGS PATIENT HAS TAKEN FOR THIS DIAGNOSIS:** (Provide to the best of your knowledge)*

IMPORTANT NOTE:
Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Drug Name, Strength, Frequency	*Dates started and stopped or Approximate Duration*	*Describe Response, Reason for Failure, or Allergy*

ATTACH OR LIST BELOW RELEVANT LABORATORY VALUES AND DATES:

Date	*Test*	*Value*

MEDICAL JUSTIFICATION OR OTHER NOTES:

SIGNATURE

***Signature of Requestor:**_____	*Date:

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