South Carolina

Prior Authorization (Pharmacy Benefit) Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029. You can also use CoverMyMeds to submit prior authorization requests, saving you time and often delivering real-time determinations. Visit the member's health plan website to begin using this free service.

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID Number:			NPI Number:	Specialty:	
Date of Birth:	Phone:		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	ZIP:	City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): _____

What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication[s]/strengths tried, length of trial and reason for discontinuation of each medication.)

What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication[s] with the associated contraindication or specific issues resulting in intolerance to each medication.)

Are there any supporting labs or test results? (Please specify.)

Quantity Limit Requests:

What is the quantity requested per day? _____

What is the reason for exceeding the plan limitations?

- ☐ Plan limitations are exceeded for titration or loading dose purposes.
- ☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime).
- ☐ Requested strength/dose is not commercially available.
- ☐ Patient requires a greater quantity for the treatment of a larger surface area (topical applications only).
- ☐ Other: _____

Information on this form is accurate as of this date:

Prescriber's Signature:	**Date:**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received**.
For more information about the prior authorization process, please contact us at 855-811-2218 Monday – Friday from 8:30 a.m. – 5 p.m. Eastern time.

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