buckeye health plan

# General Specialty Medication PA Form

## Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Phone: 866.399.0928 Fax: 844.205.3383 https://www.covermymeds.com/main/prior-authorization-forms/

### Patient Information

| | | | |
|---|---|---|---|
| Last Name: | First Name: | Middle: | DOB: ____/____/_____ |
| Address: | City: | State: | Zip: |
| Daytime Phone: | Evening Phone: | Sex: ☐ Male ☐ Female | |

### Insurance Information (Attach copies of cards)

| | | | |
|---|---|---|---|
| Primary Insurance: | | Secondary Insurance: | |
| ID # | Group # | ID # | Group # |
| City: | State: | City: | State: |

### Physician Information

| | | | |
|---|---|---|---|
| Name: | Specialty: | NPI: | |
| Address: | City: | State: | Zip: |
| Phone # ( ) | Secure Fax #: ( ) | Office contact: | |

### Primary Diagnosis

ICD-10 code: _____

Description in words: _____

### Prescription Information

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| | | | | |

### Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

***Note: This form is to be used to request review for Specialty Medication where there is no drug specific form. For non-specialty medication, please use US Script Prior Authorization form.***

Patient's weight: _____ kg Patient's height: _____ inches

1. Is the patient currently treated with this medication? ☐Yes ☐No
2. If continuation of therapy, how long has the patient been on treatment? _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐Yes ☐No
4. Please indicate previous treatment and outcomes:

| 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 part of the exception criteria.

5. Please state rationale for request / pertinent clinical information (**required for all prior authorizations**): _____

_____

_____

_____

**Physician's Signature** _____ **Date:** _____ ☐ DAW