Care1st Health Plan of Arizona: Pharmacy Prior Authorization Request form

Phone: 1-866-560-4042 (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):		

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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:

Pharmacy Department
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Visit our website at www.care1staz.com