Prior Authorization Request

EOC: Women's Contraceptives ACA Exception Form

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit ServeYouRx.com or call 800-759-3203.

Fax completed form to: 800-480-4840, Attn: Authorizations **Note:** Blank fields or illegible responses may delay the review process.

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ MI: _____

Date of Birth: __________ Member ID #: ______________ Group #: ______________

Permanent Address: ______________ City: ______________ State: ______ ZIP: __________

Primary Phone #: ______________ Secondary Phone #: ______________

☐ Mobile ☐ Work ☐ Home ☐ Mobile ☐ Work ☐ Home

PRESCRIBER INFORMATION

Name: ______________ Specialty: ______________

Address: ______________ City: ______________ State: ______ ZIP: __________

NPI: ______________ State License ID: ______________

Office Contact: ______________ Fax: ______________ Phone: ______________

REQUESTED MEDICATION

Drug Name: ______________ Strength: ______________ Frequency: ______________

Directions: ______________

Expected Duration of Therapy: ______________ If this is a continuation of therapy, provide start date: __________

☐ **Pertinent medical history or information for this patient is attached that may support approval**

☐ **Urgent review requested**

REQUIRED INFORMATION

1 The Patient Protection and Affordable Care Act (PPACA or ACA) requires non-grandfathered health plans to cover a full range of women's contraceptive products at no cost share for eligible members. An exceptions process is available to allow $0 coverage for certain women's contraceptive products if deemed medically necessary by the individual's medical provider.

2 Diagnosis for use: ______________

3 Diagnosis code (ICD): ______________

4 Please list all medications previously tried and failed for the treatment of this diagnosis.

☐ Medication/therapy #1: ______________

☐ Medication/therapy #2: ______________

☐ Medication/therapy #3: ______________

☐ Medication/therapy #4: ______________

5 I certify that in my medical opinion, the requested medication, dose, and duration is medically necessary for the condition being treated: ☐ Yes ☐ No

Prescriber Signature: ______________

Today's Date (month/day/year): __________

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.