

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.

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