Coordinated Care Corporation Prior Authorization Request Form

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Or return completed fax to 1.800.977.4170

I. PROVIDER INFORMATION	II. MEMBER INFORMATION	
Name:	**Name:**	
NPI #:	**Member ID:**	
Office Contact:	**Date of Birth:**	
Phone:	**Height:**	**Weight:**
Fax:	**Medication Allergies:**	
Diagnosis:	**ICD-10:**	

III. DRUG INFORMATION	
Drug name and strength:	**Dosage Form:**
Directions:	**Quantity per day:**
Length of Therapy:	**Expedite/Urgent?** ☐ Yes ☐ No
Exception? ☐ Yes ☐ No	

IV. MEDICATION HISTORY	
A. Is member currently treated on this medication? ☐ Yes ☐ No	
B. Has strength or daily dose changed? ☐ Yes ☐ No	**List Change:**
C. Have you attached test results (HbA1c, genetic results, etc.) to support this request? ☐ Yes ☐ No	

V. ALTERNATIVE/CONJUNCTIVE TREATMENT HISTORY RELATED FOR THIS REQUEST		
Drug Name, Strength, Form, and Dosage	**Date(s) of Therapy**	**Reason for Discontinuation (If active, please indicate)**
1.		
2.		
3.		
4.		

NOTE: Must provide medical record evidence indicating prior use of preferred drug(s).

VI. DOCUMENT CLINICAL RATIONALE FOR USE OF MEDICATION	
Prescriber Signature:	**Date:**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.