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Prior Authorization Request Form

Prior authorization or exception requests may be submitted electronically using CoverMyMeds or using the electronic health record. For more information visit www.allumaco.com/providers. **This form should be used only when electronic means of submission are not available.**

PATIENT INFORMATION

Patient name _____

Date of birth _____

Insurance ID# _____

Daytime phone number _____

Primary Care Physician _____

PRESCRIBER INFORMATION

Prescriber name _____

NPI _____ Specialty _____

Prescriber address _____

_____

Phone number _____

Secured fax number _____

MEDICATION AND DIAGNOSIS INFORMATION

Medication _____ Strength _____ Directions _____

Anticipated Duration of Treatment ◯ Continuous ◯ Limited (specify) _____ Quantity ____ Day Supply ___

Diagnosis _____ ICD-10 Diagnosis Code(s) _____

MEDICATION HISTORY

Please indicate whether this request is: ◯ Routine ◯ Urgent*

*Urgent requests are those for medical conditions that could seriously jeopardize the life or health of the patient, the ability of the patient to regain maximum function, or which involve a medical condition that would subject the patient to severe pain that cannot be managed adequately without care or treatment.

Please indicate whether you are requesting (select one):

◯ Prior Authorization
◯ Step Therapy Exception
◯ Affordable Care Act Coverage Exception
◯ Quantity Limit Exception

Please confirm the fill history for this specific medication:

◯ New start/Initial fill
◯ Renewal/Continuation of therapy

If this is a renewal/continuation of therapy, indicate when the medication was started _____

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CLINICAL NOTES SUPPORTING THE DIAGNOSIS, PLAN OF CARE, AND PREVIOUSLY TRIED AND FAILED THERAPIES IS REQUIRED FOR REVIEW. PLEASE INCLUDE THESE NOTES AS AN ATTACHMENT TO YOUR REQUEST.

List any previous medications the patient has tried and/or failed.

ADDITIONAL COMMENTS

Add comments here:

SIGNATURE OF PRESCRIBER

I attest the information provided is accurate to the best of my knowledge as documented on this form and in the attached clinical notes. I understand that the Health Plan or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber signature _____ Date _____

SUBMISSION INFORMATION

Fax to: (833) 951-1683 OR mail to: Alluma
Attn: Clinical Department
PO Box 14651 St. Louis, MO 63166