



Prior Authorization / Formulary Exception Request Fax Form

CoverMyMeds is AzCH's preferred way to receive prior authorization requests.
 Visit www.covermymeds.com/main/prior-authorization-forms/ to begin using this free service
OR FAX this completed form to (833) 546-1508.

Form must be fully completed to avoid a processing delay

For Prior Authorization Status Call: (866) 399-0928

Patient's Name (Last, First, MI)						Date of Birth ----- MM / DD / YYYY -----					
Member ID # ----- Please print clearly and enter one digit per box -----						Patient's Phone ----- Please print clearly and enter one digit per box -----					
Patient's Address, City, State, Zip						Gender <input type="checkbox"/> M <input type="checkbox"/> F		Allergies			
Provider's Name (Last, First, MI)						Provider Specialty			Contact Name		
Provider's Address, City, State, Zip						NPI #					
----- Provider's Phone ----- Please print clearly and enter one digit per box -----						----- Provider's Fax ----- Please print clearly and enter one digit per box -----					
Medication Name and Strength				Quantity		Direction for Use and Duration					
Administered: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health <input type="checkbox"/> By Patient <input type="checkbox"/> Other (specify):											
Diagnosis				ICD-10 Code				New Start with This Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Date of First Dose			
Medications Previously Tried with Dates of Use (supporting documentation required)											
Medical Justification and Supporting Information (Chart Notes required. Labs required if applicable, Height and Weight)											

For injectable drugs only:

Provider will supply drug: Yes <input type="checkbox"/> No <input type="checkbox"/>	Specialty Pharmacy Yes <input type="checkbox"/> No <input type="checkbox"/>
Total Units/Visits/Days:	The patient will obtain the medication from: The Provider <input type="checkbox"/> A Pharmacy <input type="checkbox"/>

Servicing Provider/Facility Information:

Servicing Name:	Servicing NPI:	Contact Name:
Procedure Codes:		Phone Number:
Start Date:	End Date:	

I certify that the above information is correct to the best of my knowledge.

Physician's Signature (required)	Date
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Mailing Address: Arizona Complete Health Pharmacy Department 333 E Wetmore, Suite 600 Tucson, AZ 85705

For copies of prior authorization forms and guidelines, please call (888) 788-4408 or visit the provider portal at www.AZCompleteHealth.com.