arizona complete health

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 ☐ M ☐ 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
Diagnosis	ICD-10 Code / New Start with This Medication: ☐ Yes ☐ 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**)	

Patient Location for Administration: ☐ Doctor's Office ☐ Infusion Suite ☐ Dialysis Center ☐ Home ☐ Outpatient Hospital ☐ Other (specify):

***ALSO requests for medication to be covered by a non-par provider OR outpatient pharmacy for inpatient administration should be submitted to:**
Email: AZCH_PharmacyProviderLiaison@azcompletehealth.com

Who will supply the drug? ☐ Provider's Office (Buy/Bill) ☐ Dialysis Center ☐ Specialty Pharmacy ☐ Outpatient Hospital Pharmacy ☐ Retail Pharmacy ☐ Other (specify):

Name of Provider/Facility/Pharmacy: (No response needed for retail pharmacies)

Servicing Provider/Facility Information for injectable drugs only:

Servicing Provider Name:	Servicing NPI: / Servicing TIN:	Contact Name: / Phone Number:
Procedure Codes:		Total Units/Visits/Days:
Start Date:	End Date:	

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

Physician's Signature(required)	Date

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.

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