



Prior Authorization Request

Brand Contraceptive Copay Waiver

Patient Information

Patient Name: _____
ID #: _____
DOB: ____ / ____ / ____

Provider Information

Name: _____
Address: _____

Phone: (____) _____ - _____
Drug Requested: _____

Please answer the following questions:

- Yes No Is the requested contraceptive medically necessary because the preferred contraceptives are inappropriate for this patient?
- Yes No Is the medical necessity attested to above for the specific non-preferred contraceptive drug supported by medical record documentation?

Signature of Physician

Signature of Physician: _____ Date: ____ / ____ / ____

Complete form and fax. Please do not include a cover sheet.

	State	Exchange
Colorado	844-521-6939	844-534-9057
California	844-474-3347	844-474-6219
New Hampshire	844-474-3355	844-474-6224
Connecticut	844-474-3350	844-474-6220
Georgia	844-512-9002	844-512-9003
Indiana	844-521-6940	844-471-7938
Kentucky	844-521-6947	844-471-7939
Maine	844-474-3351	844-474-6221
Missouri	844-534-9053	844-471-7940
Nevada	844-534-9054	844-471-7941
New York	844-474-3356	844-474-6226
Ohio	844-534-9055	844-471-7942
Wisconsin	844-534-9056	844-474-3340
Virginia	844-474-3358	844-474-6227
Plan Specific		
COVA – 844-474-6218		

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