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:

1. ☐ Yes ☐ No Is the requested contraceptive medically necessary because the preferred contraceptives are inappropriate for this patient?
2. ☐ 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		