





FAX Completed Form To 1.833.404.2392 Prescriber Help Desk

1.833.587.2012

Online

covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization TOPICAL CORTICOSTEROIDS (PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all info	rmation above. It must be legible, correc	ct, and complete or form will be returned.
Pharmacy NPI	Pharmacy fax	NDC
Prior authorization is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.		
Drug Name:	Strengt	th: Dosage Form:
Dosage Instructions:	Quanti	ty: Days Supply:
-		
-		
Diagnosis: Preferred Topical Corticoste		
Diagnosis: Preferred Topical Corticost Drug Name & Dose:	eroid Trial 1:	Trial Dates:
Diagnosis: Preferred Topical Corticost Drug Name & Dose:	eroid Trial 1:	Trial Dates:
Diagnosis: Preferred Topical Corticost Drug Name & Dose: Failure Reason:	eroid Trial 1: eroid Trial 2:	Trial Dates:
Diagnosis: Preferred Topical Corticost Drug Name & Dose: Failure Reason: Preferred Topical Corticost	eroid Trial 1: eroid Trial 2:	Trial Dates:
Preferred Topical Corticost Drug Name & Dose: Failure Reason: Preferred Topical Corticost Drug Name & Dose: Failure Reason:	eroid Trial 1: eroid Trial 2:	Trial Dates: Trial Dates:
Preferred Topical Corticost Drug Name & Dose: Failure Reason: Preferred Topical Corticost Drug Name & Dose: Failure Reason:	eroid Trial 1: eroid Trial 2: eason to override trial requirements:	Trial Dates: Trial Dates:

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.