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.

	Exchange
Maryland	877-671-6773
Texas	877-671-6775
Florida	877-671-6721