



# 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.

	<b>Exchange</b>
<b>Maryland</b>	877-671-6773
<b>Texas</b>	877-671-6775
<b>Florida</b>	877-671-6721

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