



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
Washington	855-892-0981

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