

Prior Authorization / Formulary Exception Request Fax Form

CoverMyMeds is AzCH's preferred way to receive prior authorization requests. Visit go.covermymeds.com/EnvolveRx to begin using this free service OR FAX this completed form to (855) 554-5233.

Form must be fully completed to avoid a processing delay		For Prior Authorization Status Call: (888) 788-4408	
Patient's Name (Last, First, MI)		Date of Birth MM / DD / YYYY	
			/
Member ID # Please print clearly and enter one digit per box	Patient's Phone	Please print clearly and	enter one digit per box
Patient's Address, City, State, Zip Gender M F Allergies			Allergies
Provider's Name (Last, First, MI)		Provider Specialty	Contact Name
Provider's Address, City, State, Zip NPI #			
Provider's Phone Please print clearly and enter one digit per box	(S Fax Please print clearly at	_
Medication Name and Strength	Quantity Direction for Use and Duration		
Administered: Doctor's Office Dialysis Center Home Health By Patient Other (specify):			
Diagnosis ICD-10	Code New Start with This Medication: ☐ Yes ☐ No		
		If No, Date of First Dose	
Medications Previously Tried with Dates of Use (supporting documentation required) Medical Justification and Supporting Information (Chart Notes required. Labs required if applicable, Height and Weight)			
For injectable drugs only:			
Provider will supply drug: Yes No	Specialty Pharm	Specialty Pharmacy Yes No No	
Total Units/Visits/Days:	The patient will obtain the medication from: The Provider A Pharmacy		
Servicing Provider/Facility Information:			
Servicing Name: Servicing NPI:	Contact Name: Phone Number:		
Procedure Codes:			
Start Date: End Date:			
I certify that the above information is correct to the best of my knowledge.			
Physician's Signature(required)		Date	
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Mailing Address: Arizona Complete Health Pharmacy Department 5225 E. Williams Circle, Suite 4000 Tucson, AZ. 85711			
For copies of prior authorization forms and guidelines, please call (888) 788-4408 or visit the provider portal at www.AZCompleteHealth.com .			