COMMERCIAL MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Date of Submission: _____

For a complete list of all medications that require a prior authorization, please visit AvMed's website at www.avmed.org/prescriptions

- **For medications administered in the physician's office, participating facility, or in the home by a healthcare practitioner, please select the following link: Prior Authorization Requirements (Office, Outpatient Facility, Home Health)**
- **For medications obtained at the pharmacy, please select the appropriate formulary based on the member's enrollment**

PATIENT INFORMATION

Member ID	A	**Date of Birth**		**Is Member Pregnant?** ☐Yes ☐ No	
Member Name		**Height**		**Weight**	
Diagnosis		**Diagnosis (ICD-10) Code**			

DELIVERY – ADMINISTRATION INFORMATION

☐ **In-office (MD to supply and administer)**

☐ **Retail pharmacy Pickup**

☐ **Home Health Provider**

☐ **Outpatient Facility** ☐ **Infusion Suite**

Name of Facility/Suite: _____

Facility/Suite Provider Number: _____

If you are requesting medication delivery to your office, enrollment in the CVS Specialty Medication Delivery Program is required.

Please choose below:

☐ **CVS Specialty – Patient delivery (self-administered specialty meds)**

☐ **CVS Specialty – MD office delivery**

CVS Specialty can be reached at :
Phone: 866-638-8311 Fax:800-323-2445

ADDITIONAL MEDICATION INFORMATION FAX 877-535-1391

Please attach all Office Notes and Current Lab Results
Incomplete forms and/or inadequate documentation may result in a denial

Drug Name		**Quantity**	
Directions for Use		☐ **New Therapy**	☐ **Continuation of Therapy**

If Continuation of Therapy, indicate the member's therapeutic response:

Duration of Therapy		**Procedure Code**	
Reason for Request			

PHYSICIAN INFORMATION

Prescriber Name		**Prescriber Specialty**		
Form Completed By		**AvMed Provider Id #**		
NPI #		**Office Number**		**Ext**
Contact Name		**Fax Number**		

Please remember to review and complete all fields on this form and include appropriate Office Notes and Labs with all requests

Fax completed form to AvMed at 1-877-535-1391