

11/14/2024

Prior Authorization Form

Internal Use Only

AMERICAN AIRLINES - ACTIVES

Preventive Services Contraceptive Zero Copay Exception\*

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-487-9257**.

Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Preventive Services Contraceptive Zero Copay Exception\*.

Drug Name (select from list of drugs shown)

Other, Please specify

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Comments: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Has the attending health care provider determined the requested drug to be medically necessary for the patient as a preventive service?

Y N

[No further questions]

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date