

Cough & Cold Products - Maryland Prior Authorization Request Form

Please complete this entire form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826.

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Inforn	nation							
First Name:	Last Name:			Memb	Member ID:			
Address:								
City: State:					ZIP Code:			
Phone: DOI			DOB:			Allergies:		
Primary Insurance Information	(if any):	1			1			
Is the requested medication	on: □ New or □	Continuat	ion of Thera	apy? If continuation,	list sta	rt date:		
Is this patient currently he	ospitalized?	Yes □ No	If recently	discharged, list disc	harge	date:		
Section B - Provider Inform	mation							
First Name:			Last Name:				M.D./D.O.	
Address:	Address:			City:			ZIP code:	
Phone:	Fax:				Specia	Specialty:		
Office Contact Name / Fax atte	ention to:							
Section C - Medical Inform	ation							
Medication:						Strength:		
Directions for use:						Quantity:		
Diagnosis (Please be specific & provide as much information as possible):							DDE:	
Is this member pregnant?		If yes,	what is this	member's due date? _				
Section D - Previous Medi						Reason	n for failure /	
Medication Name	Strength	Dire	ctions	Dates of Therap	Dates of Therapy discontinu			
Section E – Additional info	rmation and E	xplanation	of why pref	erred medications w	ould no	t meet the	e patient's needs:	
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Member First	name:	Member Last name:	Member DOB:			
Clinical and Drug Specific Information						
ALL REQUESTS						
□ Yes □ No	Does the patient have a history of failure, contraindication, or intolerance to any preferred cough and cold products? (If yes, complete Section D above)					
PATIENTS LESS THAN 18 YEARS OF AGE						
□ Yes □ No	Does the prescriber attest they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary? If yes, document rationale for use:					
□ Yes □ No	Does the patient have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)? If yes, list comorbid condition:					
□ Yes □ No	Has the patient tried and failed any non-opioid containing cough and cold remedies? (If yes, complete Section D above)					
QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD						
□ Yes □ No	Does the prescriber atte	st that a larger quantity is medically ne	cessary?			
□ Yes □ No	Does the prescriber attest they are aware of patient's current opioid therapy and morphine milligram equivalent (MME) dose and feels the treatment with the requested product is medically necessary?					

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Provider Signature:

error, please notify the sender immediately.