Reset

PRIOR AUTHORIZATION REQUEST FORM

Alluma™

Prior authorization or exception requests may be submitted electronically using CoverMyMeds or using the electronic health record (where available). For more information visit www.allumaco.com/providers. **This form should be used only when electronic means of submission are not available.**

PATIENT INFORMATION

Patient Name _____
Date of Birth _____
Insurance ID # _____
Daytime Phone # _____
Primary Care Physician _____

PRESCRIBER INFORMATION

Prescriber Name _____
Prescriber NPI _____ Specialty _____
Name of Office Contact _____
Phone # _____
Secure Office Fax # _____

MEDICATION AND DIAGNOSIS INFORMATION

Medication _____ Strength _____ Directions _____
Anticipated Duration of Treatment ◯ Continuous ◯ Limited (specify): _____ Quantity _____ Day Supply _____
Diagnosis _____ ICD-10 Diagnosis Code(s) _____

MEDICATION HISTORY

Please indicate whether this request is: ◯ Routine ◯ Expedited/Urgent* review requested

*Urgent requests are those for medical conditions that could seriously jeopardize the life or health of the patient, the ability of the patient to regain maximum function, or which involve a medical condition that would subject the patient to severe pain that cannot be managed adequately without care or treatment.

Please indicate whether you are requesting (select only one): ◯ Prior Authorization ◯ Step Therapy Exception ◯ Affordable Care Act Coverage Exception ◯ Quantity Limit Exception

Please confirm the fill history for this specific medication: ◯ New Start/Initial Fill ◯ Renewal/Continuation of Therapy

If this is a renewal/continuation of therapy, indicate when the medication was started: _____

List any previous medications the patient has tried and/or failed and the reason for the request:

CLINICAL DOCUMENTATION SUPPORTING THE DIAGNOSIS, PLAN OF CARE, AND PREVIOUSLY TRIED AND FAILED THERAPIES **IS REQUIRED** FOR REVIEW. PLEASE INCLUDE THIS DOCUMENTATION AS AN ATTACHMENT TO YOUR REQUEST.

ADDITIONAL COMMENTS

SIGNATURE OF PRESCRIBER

I attest the information provided is accurate to the best of my knowledge as documented on this form and in the attached clinical notes. I understand that the Health Plan or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

_____ Prescriber Signature

_____ Date

SUBMISSION INFORMATION

Fax to: (833) 951-1683 OR Mail to: Alluma
Attn: Clinical Department
PO Box 14651 St. Louis, MO 63166