



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecure-forproviders/pharmacy

Egrifta Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information									
Member Name (first & last):			Date of Birth:			Gender:		Height:	
						<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:			City:			State:		Weight:	
Prescribing Provider Information									
Provider Name (first & last):			Specialty:			NPI#		DEA#	
Office Address:			City:			State:		Zip Code:	
Office Contact:			Office Phone			Office Fax:			
Dispensing Pharmacy Information									
Pharmacy Name:			Pharmacy Phone:			Pharmacy Fax:			
Requested Medication Information									
Medication request is NOT for FDA approved or compendia-supported diagnosis (circle one): Yes No				Diagnosis:			ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, specify:						<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	
<input type="checkbox"/> Continuation of therapy ONLY:	Was there positive clinical response of HbA1c within normal range?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
	Was there positive clinical response of IGF-1 within normal range?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
	Was there a decrease in waist circumference?					<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Directions for Use:			Strength:			Dosage Form:			
			Quantity:		Day Supply:		Duration of Therapy/Use:		
What medication(s) has the member tried and failed for this diagnosis? Please specify below.									
Turn-Around Time for Review									
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to gain maximum function, you can ask for an expedited decision.						
Signature: _____									
Clinical Information									
Is MALE waist circumference ≥95cm at start of therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is FEMALE waist circumference ≥94cm at start of therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is member currently receiving anti-retroviral therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a baseline evaluation within past 3 months of HgB A1C AND IGF?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Will HgB A1C be monitored every 3-4 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member at risk for medical complications due to excess abdominal fat?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does member have active malignancy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have disruption of hypothalamic-pituitary gland axis OR head trauma?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member a woman of childbearing age who is NOT pregnant AND using appropriate contraception?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.									

[Empty box for chart notes]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.