mercy care

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/completecare-forproviders/pharmacy

Platelet Inhibitors
Pharmacy Prior Authorization Request Form

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

REQUIRED: Office notes, labs and medical testing relevant to requests howing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
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				
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No		
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): Yes No	Diagnosis:		ICD-10 Code:	
Directions for Use:	Strength:		Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has member tried and failed for this diagnosis? Please specify:				

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information						
☐ **Brilinta**						
Does member have history of stent thrombosis OR restenosis?	☐ Yes	☐ No	Was member stabilized in hospital?		☐ Yes	☐ No
Is the diagnosis of Acute Coronary Syndrome (for example, unstable angina STEMI, NSTEMI)?					☐ Yes	☐ No
Does members' aspirin dose does exceed 100 mg per day?					☐ Yes	☐ No
Member does NOT have ANY of the following:	☐ Active pathological bleed		☐ History of intracranial hemorrhage		☐ Planned CABG	
☐ Renewal Requests ONLY:						
Is member at high risk of bleeding OR has significant overt bleeding?					☐ Yes	☐ No
☐ **Zontivity**						
Was member stabilized in hospital?	☐ Yes	☐ No	Does member have history of MI OR PAD?		☐ Yes	☐ No
Will medication be used with aspirin and/or clopidogrel?					☐ Yes	☐ No
Member does NOT have ANY of the following:	☐ History of stroke (TIA)		☐ Intracranial hemorrhage		☐ Active pathological bleed (peptic ulcer)	
☐ Renewal Requests ONLY						

Is member at high risk of bleeding OR has significant overt bleeding?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

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.