COVENTRY
Health Care

STANDARD Prior Authorization Agents ~ 2012

Some drugs require prior approval (preauthorization) by Coventry Health Care before the prescription will be filled at the pharmacy. Your doctor will coordinate this approval for you. If the prescription is approved, Coventry Health Care will cover the cost. You will be responsible for the copayment. If the request is not approved, it does not mean your doctor cannot prescribe the medicine for you. It means that you are responsible for paying the prescription in full. Self-administered injectable agents also require prior authorization and can be found on a separate list.

Abilify	*Diovan / Diovan HCT*	*Oforta*	*Symlin, Symlin Pen*
*Accutane**	*Edarbi*	*One Touch Verio IQ meter & strips*	Tarceva
Aciphex	*Edarbyclor*	*Onsolis*	*Tasigna*
*Actiq**	*Embeda*	*Opana IR*	*Tekamlo*
Actonel	*Emsam*	*Oravig*	*Tekturna / Tekturna HCT*
Actonel w Calcium	*Erivedge*	*OxyContin*	Temodar
Adcirca	*Exalgo*	*Perforomist*	Testim
Adderall XR,***	*Exforge / Exforge HCT*	*Potiga*	*Teveten / Teveten HCT*
Afinitor	*Exjade*	*Prevacid solutabs* ~*	Thalomid
Ampyra	Femara*	*Pristiq*	TOBI
Amturnide	*Fentora*	*Promacta*	Tracleer
Arimidex*	*Ferriprox*	*Proventil HFA*	*Tribenzor*
Aromasin*	*Focalin XR***	*Provigil**	*Twynsta*
Atacand / Atacand HCT	*Fosamax-D*	Pulmicort Respules^	*Tykerb*
Atelvia	*Gilenya*	Pulmozyme	*Tyvaso*
Avandamet	Gleevec	*Qualaquin*	*Vancocin* 250mg only*
Avandaryl	*Hycamtin*	Rebetol*	*Ventavis*
Avandia	*Incivek*	*Regranex*	Vfend
Avapro / Avalide**	*Inlyta*	*Relistor*	*Victoza*
Azor	Insulin Pens (intermediate & long-acting: Novopen, Humulin Pen, etc)	*Revatio*	*Victrelis*
Blood Glucose Meters / Strips (Non-LifeScan)	*Jakafi*	*Revlimid*	*Viibryd*
Boniva	*Kalydeco*	*Ritalin LA***	*Votrient*
Brovana	*Korlym*	*Rozerem*	*Vytorin 10/80*
Buphenyl	*Kuvan*	*Sabril*	*Vyvanse #*
Butrans	*Lamictal ODT*	*Samsca*	*Xalkori*
Bydureon	*Lamictal XR*	*Sancuso*	Xeloda
Byetta	*Lazanda*	*Savella*	Xenazine
Caprelsa	*Letairis*	*Selzentry*	*Xifaxan 550mg*
Cayston	*Lovaza*	Seroquel* >	*Xopenex HFA*
Chenodal	*Lumigan*	Singulair	*Xyrem*
Coartem	*Lyrica*	*Skelid*	*Zavesca*
Colcrys	*Malarone*	Sporanox capsule*, oral soln	*Zelboraf*
Concerta*,**	*Marinol*	*Sprix*	*Zioptan*
Copegus*	*Metadate CD***	*Sprycel*	Zocor 80mg
Cymbalta	*Nexavar*	Stimate	*Zolinza*
Daliresp	*Noxafil*	Suboxone	*Zytiga*
*Daytrana***	*Nucynta / Nucynta ER*	*Subsys*	Zyvox
Dexilant	*Nuedexta*	Subutex	
Dificid	*Nuvigil*	Sutent	

* indicates generic available
Italics indicate non-formulary agents
> indicates PA required for long term use of doses less than 150mg/d
~ indicates Prior Auth required for age 1yr and over
^ indicates Prior Auth required for age 5yr and over
** indicates Prior Auth required for age 19yr and over
# indicates Prior Auth required for age 19yr and over; Step Therapy required for age 18yr and under

Under two tier managed formulary benefits, formulary exception criteria must be met in addition to the prior authorization criteria.

This is the most current list at the time of printing and is subject to change.
Last update May 2, 2012

COVENTRY
Health Care

PRIOR AUTHORIZATION MEDICATION – GENERAL REQUEST FORM

Coverage Policy: For medications that require prior authorization, when the only information required is a diagnosis, and previous treatment trials and failures. When requesting a medication that requires additional, more specific information (clinical notes, lab values, test results, etc) please use the prior authorization form specific to that medication (eg: Byetta, Procrit, testosterone).*

Requests meeting the following criteria will be considered:

- Use for an FDA-approved indication
- Intolerability or failure to other medications used to treat the stated diagnosis, after an adequate trial

*** A listing of all drugs that require prior authorization can be found at www.cvty.com.**

PLEASE SEND COMPLETED FORM TO COVENTRY HEALTH CARE – PHARMACEUTICAL SERVICES
FAX:Q3 (877) 554-9139 PHONE: (877) 215-4098

Requesting Physician:	Office Contact:
Call Center ID: Tax ID Number:	Plan ID: Benefit:
Office Fax Number:	Phone Number:
Office Address:	

MEMBER INFORMATION

Patient Name:	DOB:
Member ID#:	Date of Request:

MEDICATION INFORMATION

1.	**Drug Requested:** **Dose:** **Duration:**
2.	**Diagnosis:**
3.	**List other formulary agents tried:** ***(include all office notes and supporting documentation)*** **Drug:** _____ **Date(s) used:** _____ **Outcome:** _____ **Drug:** _____ **Date(s) used:** _____ **Outcome:** _____ **Drug:** _____ **Date(s) used:** _____ **Outcome:** _____ **Drug:** _____ **Date(s) used:** _____ **Outcome:** _____
4.	**Other supporting information:** ***(Supporting clinical documentation is particularly important when requesting an exception to coverage criteria for reasons of medical necessity.)***
Physician's Signature:	

CHCH 2025-3 (04/10)

Visit our Website at WWW.CVTY.COM