GEHA
The Benefits of Better Health

Cuprimine/Disotate/Endrate (or other chelating drug) Authorization

Please complete this form and fax it to (816) 257-4516. Date of request: _____

Patient-required information

*Patient name: _____ / ____ / _____ Phone: _____
First MI Last

*Patient address: _____
Street

_____ / _____ / _____
City State Zip

*Member ID: _____ *Patient date of birth: _____ / _____ / _____ Sex: ❑ M ❑ F

*Member address: _____
Street

_____ / _____ / _____
City State Zip

Physician-required information

*Physician name: _____ / ____ / _____
First MI Last

*Physician tax ID number: _____
(Required information to process)

*Physician address: _____
Street

_____ / _____ / _____
City State Zip

*Phone: _____ *Fax: _____

Your patient's benefit plan requires prior authorization for certain medications. You have prescribed a medication that requires a prior authorization for your patient. Your patient has requested a review to determine if the drug is consistent with plan rules for coverage.

*Drug name: _____ *Drug dosage: _____

*Duration: _____ *ICD-CM code/s: _____

- Copies of current patient clinical information including History and Physical exam and Treatment Plan from the past 3 to 6 months, as well as any pertinent tests completed with results.

IMPORTANT: All required information detail and documents must be included when faxing this completed authorization form. GEHA will notify you of our determination after reviewing the submitted information.

**Required information. Request cannot be processed without this information being included.*

Questions: Call Customer Service at 800.821.6136. Fax completed form to 816.257.4516.

Payable benefits are subject to the terms and conditions of the Health Benefit Plan.