



PRIOR AUTHORIZATION REQUEST FORM

FAX COMPLETED FORM TO
877-326-2856

**In order to process this request, please complete all fields.*

PATIENT INFORMATION (if different from card holder)

Patient Name		Date of Birth (MM/DD/YYYY)
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Member ID	Medication Allergies	Patient Phone

PROVIDER INFORMATION

Prescriber Name	NPI#	DEA#
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

PHARMACY INFORMATION

Pharmacy	Pharmacy Phone	Pharmacy Fax
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MEDICATION REQUESTED

Drug Name	Strength	Quantity (per month)	Dose Form (oral, injection, etc)
Expected Duration of Therapy	Directions (Sig)	Diagnosis	
Patient currently being treated with the medication? <input type="checkbox"/> Yes; Date started mm/dd/yy_____ <input type="checkbox"/> No			

MEDICATION JUSTIFICATION: Include all other relevant medication tried and results

Please indication previous treatment and outcomes below

Previous Medication	Strength	Qty	Directions (Sig)	Dates (mm/dd/yy-mm/dd/yy)	Discontinuation Reason

ADDITIONAL RELEVANT OR CLINICAL INFO (please attach relevant labs/clinical notes)

FOR INTERNAL USE ONLY
APPROVED:
DENIED:
RETURNED:
PA#:
REQUEST RECEIVED:
PROVIDER CONTACT:
PHARMACY CONTACT:
PATIENT CONTACT:

Provider Signature	Date
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