# 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: ☐ Female ☐ 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

## 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? ☐ Yes; Date started mm/dd/yy_____ ☐ 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 |
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**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