



# PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: \_\_\_\_\_

### SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW**  or a **CONTINUATION of THERAPY** ? If so, start date: \_\_\_\_\_

Is this patient currently hospitalized?  Yes  No

### SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:

Office Contact Name / Fax Attention to: \_\_\_\_\_

### SECTION C - MEDICAL INFORMATION

Medication: \_\_\_\_\_ Strength: \_\_\_\_\_

Directions for use: \_\_\_\_\_

Diagnosis (Please be specific & provide as much information as possible): \_\_\_\_\_ ICD-9 CODE: \_\_\_\_\_

Check here if member has diagnosis of HIV/AIDS

Is this member pregnant?  Yes  No If yes, what is this member's due date? \_\_\_\_\_

Explanation of why the preferred medication(s) would not meet your patient's needs (Additional documentation may be faxed with this form to assist with the determination of medical necessity):

#### Other Medications Tried

<u>Medications</u>	<u>Strength</u>	<u>Directions</u>	<u>Dates of Therapy</u>	<u>Reason for failure / discontinuation</u>

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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