FUTURE SCRIPTS Secure

Prior Authorization Form

General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ Gender Edit ☐ Quantity Edit ☐ Age Edit ☐ Prior Authorization

Drug Requested _____ Quantity _____
(one drug per form only) (qty. edit only)

Is generic substitution acceptible? ☐ **Yes** ☐ **No**

PATIENT INFORMATION	**PRESCRIBER INFORMATION**
PATIENT'S NAME:	**PRESCRIBING PHYSICIAN:**
DATE OF BIRTH:	**SPECIALTY:**
PATIENT'S ADDRESS	**PROVIDER NPI:**
PATIENT ID:	**OFFICE ADDRESS:**
PATIENT'S TELEPHONE NUMBER:	**OFFICE CONTACT:**
OFFICE TELEPHONE NUMBER:	**OFFICE FAX NUMBER:**
CITY: **STATE:** **ZIP:**	**CITY:** **STATE:** **ZIP:**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

**** MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE ****

1. **PROVIDER SPECIALTY** (specify all) _____
2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all) _____
3. **MEDICATION HISTORY:** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	**Duration of therapy** (include dates)	**Currently prescribed**	**Complaint**
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Please add any other supporting medical information that may be useful in the decision making process including contraindications to medications related to the diagnosis:

_____

_____

_____

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL