



# Drug Prior Authorization Request Form

**Fax** completed form to **217-524-7264**, or call 1-800-252-8942 and provide all information requested below

Typically, if a drug requires prior approval, alternatives are available without prior approval. To find an alternative that is available without prior approval, see the Department's Preferred Drug List at <http://www.hfs.illinois.gov/preferred/> or search for prior approval requirements by drug at <http://www.ilpriorauth.com/>

<p><b>Patient information (required):</b></p> <p>Name: _____</p> <p>DOB: _____</p> <p>Nine-Digit HFS Recipient #: _____</p>	<p><b>Prescriber information (required):</b></p> <p>Name: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>NPI #: _____</p>
<p><b>Pharmacy information (required only when pharmacy is the requesting provider):</b></p> <p>Pharmacy Name: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>NPI #: _____</p>	<p><b>Contact person for this request (required):</b></p> <p>Name: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>

Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

NDC# (if available): \_\_\_\_\_ Effective begin date: \_\_\_\_\_  New prescription  Renewal

Directions for use including length of treatment: \_\_\_\_\_

1. Indication, Diagnosis or ICD-9 Code: \_\_\_\_\_

2. Please list **all** medications previously tried for this indication and description of failure (e.g., side effect, intolerance):

Additional information or reason for requesting drug (please provide specific justification for using this medication instead of one that does not require prior authorization):

If you are requesting an override of a specific limitation, please indicate by checking the appropriate box:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Age Override        | <input type="checkbox"/> Three Brand Limit Override        | <input type="checkbox"/> Brand Name Override      |
| <input type="checkbox"/> Sex Override        | <input type="checkbox"/> Maximum/Minimum Quantity Override | <input type="checkbox"/> Emergency 72 hour supply |
| <input type="checkbox"/> Daily Dose Override |  |   |

Prescriber or designee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: Post approvals may be allowed in certain circumstances.  
For further information, see the Pharmacy Provider Handbook at <http://www.hfs.illinois.gov/handbooks/>