Medication Prior Authorization Request

ILLINOIS

Fax: 855-580-1695

Instructions:

1. Only 1 medication per form
2. All fields must be completed and legible for review
3. Fax completed form to the number above. Prior Authorizations *cannot* be completed over the phone

Date of Request:	

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name and Specialty:
Member ID #:	NPI #:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Patient Phone:	Contact Person:

Diagnosis and Medical Information		
Medication:	Strength & Route of Administration:	Frequency:
Height & Weight:	Expected Length of Therapy:	Quantity:

BMI:	Date Calculated:	Blood Pressure:	Taken On:

Diagnosis Related to Medication Request:	
Drug Allergies:	

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

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Previous use of non-authorized and prior authorized medications tried and failed for this condition:

Name of Medication	Reason for Failure	Date of Failure

You must include the most recent relative laboratory results to ensure a complete PA review.
