

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: <input type="checkbox"/> Male <input type="checkbox"/> 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:			

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.			

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