

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax to: **1-844-881-4926**. If you have questions, please call **1-866-331-2243**

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 <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation: list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____

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