



Please complete ALL information below and fax your request to 1-888-671-5285

General Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
What is the patient's diagnosis for the medication being requested (specify all)?
ICD-10 Code(s): _____

Medication history (Please list any previous or current therapy related to the diagnosis, using drug names and dates):		
Drug Name (dose & frequency)	Duration of therapy (include dates)	Currently prescribed
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Quantity Limit Requests:
 What is the quantity requested per MONTH? _____
 Is there documentation of the inability to reach the requested dose with commercially available dosage forms? Yes No
 Is there documentation the dose requested is medically necessary? Yes No
 If YES, please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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