Prior Authorization Form

Plan/Medical Group Name

Phone/Fax Number

Please enter a valid phone number.

Patient Information

This must be filled out completely to ensure HIPAA compliance

Name

First Name Last Name

MI

Gender

Male Female

Phone Number

Please enter a valid phone number.

Address

Street Address

Street Address Line 2

Authorized Representative (if applicable)

First Name Last Name

Authorized Representative Phone Number

Please enter a valid phone number.

Insurance Information

Primary Insurance Name

Patient ID Number

Secondary Insurance Name

Patient ID Number

Prescriber Information

Prescriber Name

First Name Last Name

Speciality

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Requestor (if different than prescriber)

First Name

Last Name

Office Contact Person

First Name

Last Name

NPI Number (individual)

DEA Number (if required)

Phone Number

Please enter a valid phone number.

Fax Number

in HIPAA compliant area

Email Address

Medication / Medical and Dispensing Information

Medication Name

Type

- ○ New Therapy
- ○ Renewal

Date Therapy Initiated

Month Day Year

Duration of Therapy

Specific Dates

How did the patient receive the medication?

- ○ Paid under insurance
- ○ Other

Name

Prior Authorization Number

If known

Dose / Strength

Frequency

Length of Therapy / #Refills

Quantity

Administration

- ○ Oral/SL
- ○ Injection
- ○ Other
- ○ Topical
- ○ IV

Administration Location

- ○ Physician's Office
- ○ Patient's Home
- ○ Outpatients Hospital Care
- ○ Other
- ○ Ambulatory Infusion Center
- ○ Home Care Agency
- ○ Long Term Care

Has the patient tried any other medications for this condition?

- ○ Yes
- ○ No

ICD-9/ICD-10

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

Attestation

I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Date

Month Day Year

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Enter Clinical Information

Plan use only:

Date of Decision

Month Day Year

Status

- ○ Approved
- ○ Denied

Comments/Information Requested