PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name:	Plan/Medical Group Phone#: () Plan/Medical Group Fax#: ()									
Instructions: Please fill out all important for the review, e.g. cl						n any a	dditional (documentation that is		
Patient Information: This must be filled out completely to ensure HIPAA compliance										
First Name: Last Name:						Phone Number:				
Address:		City:			l	State:	Zip Code:			
Date of Birth:	☐ Male ☐ Female	Circle unit of Height (in/cn		- Contract of the contract of						
Patient's Authorized Represent		Authorized Representative Phone Number:					er:			
Insurance Information										
Primary Insurance Name:				Patient ID Number:						
Secondary Insurance Name:				Patient ID Number:						
Prescriber Information										
First Name: Last Nam					Specialty:					
Address:			City:	City:			State:	Zip Code:		
Requestor (if different than prescriber):				Office Contact Person:						
NPI Number (individual):				Phone Number:						
DEA Number (if required):				Fax Number (in HIPAA compliant area):						
Email Address:										
		Medication / Me	edical and	d Dispensing Info	rmation	1				
Medication Name:										
☐ New Therapy ☐ Renewa If Renewal: Date Therapy Initia				Duration of Therap	by (spec	cific dat	es):			
How did the patient receive the Paid under Insurance Nan Other (explain):	Prior Auth Number (if known):									
	T			1						
Dose/Strength: Freque		iency:		Length of Therapy/#Refil		Refills: Qua		ntity:		
Administration:	l □ Injec	tion IV	Г	Other:			l			
Administration Location: Patient's Home Long Term Care Physician's Office Home Care Agency Other (explain): Outpatient Hospital Care										

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	1	ID#:								
Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.										
1. Has the patient tried any other medications for this condition?										
Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)		Response/Reason	for Failure/Allergy						
2. List Diagnoses:			ICD-9/ICD-10:							
3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.										
Please provide symptoms, lab results with dates and/or jutility contraindications for the health plan/insurer preferred drue evaluate response. Please provide any additional clinicatexceptions) or required under state and federal laws. Attachments	ig. Lab results with dates m	nust be	e provided if needed to est	ablish diagnosis, or						
Attestation: I attest the information provided is true and a	accurate to the best of my k	knowle	edge. I understand that the	Health Plan, insurer,						
Medical Group or its designees may perform a routine au information reported on this form.	<u>-</u>									
Prescriber Signature:			_ Date:							
Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.										
Plan Use Only: Date of Decision:										
☐ Approved ☐ Denied Comments/Information Req	uested:									