Request for Medication Prior Authorization

Phone 866-984-6462 / Fax 877-355-8070

**** Only one medication request per form *** All fields must be complete and legible for review ****

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 (circle): Male Female	Office Phone: ( ) -
Date of Birth:	Office Fax: ( ) -
Patient Phone: ( ) -	Contact Person:

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Height and Weight:	Expected Length of Therapy:	Quantity:

BMI:	Date Calculated: / /	Diagnosis Related to Medication Request:
Blood Pressure:	Taken on: / /	Drug Allergies:

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

_____

_____

_____

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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. ****

Prescriber's Signature:	Date: