

Date of request: \_\_\_\_\_

## **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.

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 Ad	lministration:	Frequency:
Height and Weight:	Expected Length of Thera	apy:	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:			
** You must include the most recent relative laboratory results to ensure a complete PA review. **			
Prescriber's Signature:		Date:	

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