meridianRx Request for Medication Prior Authorization

Phone xxx-xxx-xxxx Fax xxx-xxx-xxxx

**** 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:

_____

_____

_____

_____

_____

_____

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 clinical documentation to support medical necessity (i.e. labs, charts, office notes) to ensure a complete review****

Prescriber's Signature:	Date: