

Date of request:

Request for Medication Prior Authorization

Phone 855-291-5226 / Fax 855-291-5227

** 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 Med	dical Informa	ation	
Medication:	Strength and Route of Ad	lministration:		Frequency:
Height and Weight:	Expected Length of Therapy:			Quantity:
BMI:	Date Calculated:	Diagnosis Related to Medic		lication Request:
Blood Pressure:	Taken on:	Drug Allergi	es:	
	Rationale for Price	or Authoriza	tion	
History of a medical conditi	on, allergies or other pertin	ent information	n requiring th	ne 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 the most recent relative laboratory results to ensure a complete PA review. **				
Prescriber's Signature:		Date:		

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