



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:	

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