

Date of request: ___

Request for Medication Prior Authorization

Phone 1-866-984-6462 / Fax 1-877-355-8070



** 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 Med	dical Informatio	n	
Medication:	Strength and Route of Ad	Iministration: 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 Price	or Authorization	n	
History of a medical condition ————————————————————————————————————				
Name of Medication:	Reason for Failure:		Date	of failure:
Relevant laboratory tests or	procedures. Please attach n	nost recent info to	ensure a	complete PA review:
Test:	Results:			of test:
Prescriber's Signature:		Da	ite:	

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