immediately.

For CVS Use Only: (Scan from QR)

PRIOR AUTHORIZATION REQUEST FORM -

AUTO-FAX ELECTRONICALLY TRANSMITTED: 11-10-2011 13:16

PRIOR AUTHORIZATION REQUIRED – ACTION REQUIRED

As the prescriber, this patient's insurance company requires that you call the following number to provide authorization for this prescription. Your patient and our pharmacy appreciate you making this call as soon as possible.
TP Prior Auth Phone: 800-235-4357

Action Taken:

PA Authorization#_____ PA Authorized as of_____ Denied_____

Prescriber Information:		**Pharmacy Information:**	
Name:	MAHMOUD YASSIN	From:	**CVS/Pharmacy**
Address:	115 LACEY RD FORKED RIVER, NJ 087314235	Store Number:	356
		Address:	51 BANANIER DR. TOMS RIVER, NJ 08755
Phone:	609-971-0010	Phone:	732-244-1707
Fax:	609-242-1906	Fax:	732-736-1426

Patient Information:		**Third Party Information:**	
Name:	DAMBROSKI, PATRICK	Name:	EXPRESS SCRIPTS
DOB:	05-01-2000	Cardholder ID:	8833099134
Address:	901 7TH AVE NJ, 087570000	Group Number:	Q5UV
		Person Code:	
		Relationship:	3
Phone:	732-557-6984	TP Prior Auth Phone:	800-235-4357

New Prescription	**Original Prescription**	
Medication:	Rx#:	1173672
	Drug:	SINGULAIR 5 MG TABLET CHEW
Quantity:	Qty. Prescribed:	30.0 EA
Refills:	Prescribed Refills:	0
SIG:	Date Written:	11-10-2011
	SIG:	TAKE 1 TABLET BY MOUTH EVERY DAY

Pharmacy Comments:

Prescriber Comments:

Prescriber's Name (Printed): _____ Prescriber's DEA # _____

Transmitted By:_____(TX ONLY) DPS# / Oral Code _____ (TX/HI ONLY)

Prescriber's Signature: _____ Date: _____

Massachusetts Only: Interchange is mandated unless Practitioner Writes the words "No Substitution"