# Request for Medication Prior Authorization

Phone 866-236-5976 Fax 844-316-6544

****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: |
|---|---|