



## 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: _____ _____ _____			
<b>**You must include clinical documentation to support medical necessity (i.e. labs, charts, office notes) to ensure a complete review**</b>			
Prescriber's Signature:		Date:	

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.