



# PHARMACY Medication Prior Authorization Request Form

FAX: (877) 422-8130 Phone: (800) 322-8670

To ensure a timely response, please fill out the form completely and legibly.

A decision will be rendered within 24 hours of receipt of the request if all the required information is present.

If the request lacks sufficient information to render a decision, the prescriber will be notified of the required information within 24 hours of receipt of the request, and a decision will be rendered within seven (7) days from the initial date of the request.

|                              |                |                     |      |
|------------------------------|----------------|---------------------|------|
| Member Name Last, First)     | Member ID#     | DOB                 | Date |
| Requesting Provider Name     | NPI:           | PCP ( if different) |      |
| Office Contact Person        | Direct Phone # | Fax #               |      |
| Diagnosis 1 (include ICD-10) | Diagnosis 2    | Diagnosis 3         |      |

**Please send all pertinent clinical documentation with this fax.**

**Use of pharmaceutical samples cannot be accepted as justification.**

|  |           |                  |               |
|--|-----------|------------------|---------------|
| Name of Medication   | Dosage    | Quantity/ Amount | Refills (<12) |
| Sig/Instructions   | Allergies |                  |               |
| List Formulary Medications Tried. Include dates of treatment and response to treatment of each drug. |           |                  |               |
| List Formulary Medications Contraindicated / Reason  |           |                  |               |

Continuation of therapy. Recent clinical documentation of response to medication and other clinical evidence supporting continuation of therapy is required.

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Date Revised: October 2017