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 with 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.

Date Revised: October 2017