Prior Authorization Request Form

SECTION I — REVIEW ***PLEASE COMPLETE AND FAX TO: 866-816-2136*** ***Questions? Call*: 833-464-9600**

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or their ability to regain maximum function.

SECTION II — PATIENT INFORMATION

Name:	Member ID#:	DOB:	Phone:	
Address:	City:		State:	ZIP Code:

SECTION III — PRESCRIBER INFORMATION

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name & Phone:		

SECTION IV — DRUG INFORMATION

Requested Drug Name & Strength & Dosage Form:			
Directions for Use:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated):_______________________________

Is brand medically necessary? ☐ Yes ☐ No If Yes, please explain:

SECTION V — PATIENT CLINICAL INFORMATION

Height:	Weight:	☐ Male ☐ Female
Patient's diagnosis related to this request:		ICD-10 Code:

SECTION VI — RELEVANT LABORATORY OR TEST VALUES AND DATES (attach or list below):

SECTION VII — ALTERNATIVE MEDICATIONS TRIED & REASONS FOR DISCONTINUATION

SECTION VIII — ANY OTHER INFORMATION PRESCRIBER FEELS IS IMPORTANT TO THIS REVIEW

Prescriber Signature : ____Date:___________________________

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