



Request for Prior Authorization

Fax to: Prior Auth Desk (888) 863-2462

Date of Request: _____

NOTE: THE TURNAROUND TIME IS 72 HOURS OR NEXT BUSINESS DAY

Physician's Name: _____ Physician's Specialty: _____

Physician's DEA#: _____

Physician's Phone #:(_____) _____ Physician's Fax #:(_____) _____

Patients Name: _____ DOB: _____ Gender: _____

ID#: _____ Patient's Diagnosis: _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Has this patient tried other medications for this condition? (List drug and duration)

Clinical rationale for selected drug usage: _____

Provide clinical documentation including information regarding trial and failure of formulary agents to support your prior authorization request.

Pertinent Laboratory Tests or Procedures and Results: _____

Is patient currently taking drug? _____ If so, how long? _____

***** All fields must be complete and legible for Prior Authorization Review*****

****Please note that prior authorizations will not be done over the phone****

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