**General Prior Authorization Form**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

- Gender Edit
- Quantity Edit
- Age Edit
- Prior Authorization

**Drug Requested**

(one drug per form only)

Drug Requested: __________________________

**Quantity**

(only for quantity edit)

Quantity: __________________________

**Date:** __________________________

**Patient Name:** __________________________

**Provider NPI:** __________________________

**Prescribing Physician:** __________________________

**Office Contact:** __________________________

**Office Fax #:** __________________________

**Office Phone:** __________________________

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

***MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE***

1. **PROVIDER SPECIALTY** (specify all)

2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all)

3. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

<table>
<thead>
<tr>
<th>Drug Name (dose and frequency)</th>
<th>Duration of therapy (include dates)</th>
<th>Currently prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

a. Is the patient currently not compliant on the regimen specific to the diagnosis? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision-making process:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL