



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

The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.