RX AMERICA
221 N Charles Lindbergh Drive
Salt Lake City, Utah 84116

MIDWEST HEALTH PLAN

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****