



PRIOR AUTHORIZATION REQUEST FORM
For Medication

DATE OF REQUEST: _____
MEMBER INFORMATION
NAME _____
ID # _____
BIRTHDATE _____
PROVIDER INFORMATION
NAME _____
NPI # _____
ADDRESS _____
PHONE # _____ FAX # _____
CONTACT NAME _____
PROVIDER SIGNATURE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

Drug Requested: _____ Dose/frequency: _____
If not obtained at a pharmacy for self administration:
Diagnosis _____ ICD-9 code _____
Previous Medication History Rationale for Discontinuation
Rationale for Request (co-morbidities, allergies, etc.)
Submit chart notes to identify all of the following:
PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN.
FAX THIS REQUEST TO:
Commercial 1-800-376-6373
Medicare Part D 1-800-401-0915