



Prior Authorization Request Form

THIS FORM IS TO BE USED BY PRESCRIBERS ONLY and REQUIRES PRESCRIBER SIGNATURE

This form is being used for:

Check all that apply: Initial Request Continuation of Therapy/Renewal Request Request for Compound
 Other (please specify): _____

Patient Information:

Patient Name: _____ DOB: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Member ID#: _____ Plan Name: _____
Requestor's Name & relationship to enrollee (if not patient or prescriber): _____

Prescriber Information:

Prescribing Clinician: _____ Office Phone #: _____
Specialty: _____ Office Secure Fax #: _____
NPI #: _____ DEA: _____
Address: _____ City: _____ State: _____ Zip: _____

Medication Information

Quantity Limit Requests

Requested Medication: _____
Strength: _____ Dosage Form: _____
Quantity: _____ Day supply: _____
Directions: _____
Diagnosis(es) related to request: _____
ICD-10 Code(s): _____

Please select all that apply:
 Request for titration (Provide titration schedule below)
 Tried and failed plan's quantity limit (Provide rationale below)
 Unable to dose consolidate (Provide rationale below)
 Requested strength/dose not commercially available
 Request is for insulin (Provide TOTAL daily units below)
 Other (please specify): _____

Brand Request (DAW): Yes No
If Yes, has the patient had an allergic reaction (e.g., hives/urticaria, rash, anaphylaxis) to at least 1 generic manufacturer? Yes No
If Yes, has the patient had a non-allergic reaction, therapeutic failure, or side effect with at least 2 generic manufacturers (if available) of the requested drug? Yes No
If Yes, has a MedWatch form been submitted documenting the therapeutic failure or adverse outcome experienced? Yes No

Clinical Information and History

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Tried and Failed

Supporting information such as: lab values, contraindications, allergies, or any other information relevant to this request.

Drug Allergies: _____ Height: _____ Weight: _____
Other: _____

Urgent (Complete this section ONLY if URGENT):

By signing below, you are attesting that waiting for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function.

PRESCRIBER SIGNATURE REQUIRED

Date: _____

The Prescriber confirms the above information is accurate and can be verified by patient records.

Non-Urgent (Complete this section ONLY if NON-URGENT):

PRESCRIBER SIGNATURE REQUIRED

Date: _____

The Prescriber confirms the above information is accurate and can be verified by patient records.