

Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name/Dosage Form/Strength:					
☐ Check if requesting brand			Directions for Use:		
☐ Check if request is for continuation of therapy					
Clinical Information (required)					
What is the patient's diagnosis for the medication being requested? _____					
ICD-10 Code(s): _____					
What medication(s) has the patient tried and had an inadequate response to? (Please specify <u>ALL</u> medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)					
What medication(s) does the patient have a contraindication or intolerance to? (Please specify <u>ALL</u> medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)					
Are there any supporting labs or test results? (Please specify)					
Quantity limit requests: What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
☐ Titration or loading-dose purposes					
☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
☐ Requested strength/dose is not commercially available					
☐ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____					
☐ Patient requires a greater quantity for the treatment of a larger surface area [Topical applications only]					
☐ Other: _____					
<i>Note: If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provider changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day, please have the patient's pharmacy contact the Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.</i>					

Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555

For urgent or expedited requests please call 1-800-711-4555

This form may be used for non-urgent requests and faxed to 1-844-403-1028