Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Prior Authorization Request Form (Page 1 of 2)

Member Name:	Member Information (required)			Provider Information (required)		
Date of Birth: Street Address:						
Street Address: City: State: Zip: Office Street Address: Zip: Phone: City: State: Zip: Medication Information (required) Medication Name/Dosage Form/Strength: Directions for Use: 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 ALL medication(s)/strengths triength of trial, and reason for discontinuation of each medication) What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication) What is the quantity requested per DAY?	Insurance ID#:			NPI#:	NPI#: Specialty:	
City: State: Zip: Office Street Address: Zip: Defice Street Address: Zip: Medication Information (required) Medication Name/Dosage Form/Strength: Directions for Use: Directions for Use: 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 ALL medication(s)/strengths triength of trial, and reason for discontinuation of each medication) What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication) What is the quantity requested per DAY? What is the quantity requested per DAY? What is the reason for exceeding the plan limitations? Tirration or loading-dose purposes Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at right, 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. Plases specify: Patient requires a greater quantity for the treatment of a larger surface area [Topical applications only] Other: Mote: If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to	Date of Birth:			Office Phone:		
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reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provide changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day, please have the patient's pharmacy contact the	What is the qua What is the rea Titration or I Patient is or Requested: There is a mathe same do Patient requested: Other: Note: If the patier reasons such as	antity requested per Dason for exceeding the loading-dose purposes of a dose-alternating so strength/dose is not conedically necessary just page and remain with laires a greater quantity and exceeds the maximum going on a vacation, replacement of the results of the load	the plan limitations? shedule (e.g., one tablet in the patient of the same dosing frequent for the treatment of a large of the treatment of a large of the treatment of a stolen medication.	cannot use a higher ncy. Please specifier surface area [To	commercially available y: pical applications or en per day because he/s to another medication the	he needs extra medication due to that has acetaminophen, or provider

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