HEALTH

FAX NUMBER: 1-866-678-8301
PA HELP DESK: 1-866-840-1877

Prior Authorization Request Form

Fax Completed Form to 1-866-678-8301

This form is being used for:			
Check one: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request			
Reason for request *(checkall thatapply)*: ☐ Prior Authorization ☐ Formulary Exception ☐ Quantity Exception ☐ Compound Formulary Exception ☐ Copay Tier Exception			
☐ Other *(pleasespecify)*: _____			
Patient Information			
Patient Name:	DOB:	Phone#:	
Drug Allergies :	Height/Weight:	Gender: ☐Male ☐Female	
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/xDEA:		
Address:	City:	State:	Zip:
Contact Person (if different than provider):			
Prescriber's or Authorized Representative's Signature:	**Date:**		
Medication Information			
Requested Medication:			
Strength:	Quantity:	Directions:	
Diagnosis(es) related to this request:			
ICD-10 Code(s):			
If applicable, does the prescriber acknowledge or is aware that The American Geriatrics Society (AGS) considers the requested medication to be of high risk for patients 65 years old or older? ☐ Yes ☐ No			
Is the patient currently enrolled in HOSPICE? ☐ Yes ☐ No If yes, is the requested medication being used for an indication UNRELATED to the terminal illness(es)/ condition(s)? ☐ Yes ☐ No			

Previous Therapies Tried and/or Failed

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Failure

Additional information related to this request (lab values, non-pharmacologic therapies, contraindications, risk vs benefits, explanations for exceptions/continuation of current treatment):

☐ By checking this box, I attest this is an *urgent case*, meaning that an expedited (fast) determination is necessary to prevent serious threat to life, health or the body's ability to regain maximum function; or is needed to manage severe pain.

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