

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____				
SECTION A - PATIENT INFORMATION				
First Name:		Last Name:		Member ID:
Address:				
City:		State:		Zip:
Phone:		DOB:		Allergies:
Primary Insurance:		Policy #:		Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____ (note: State Generics First program requires trial of formulary medications in the prior 6 months)				
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No				
SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:		State: Zip:
Phone:		Fax:		NPI #: Specialty:
Office Contact Name / Fax Attention to:				
SECTION C - MEDICAL INFORMATION				
Medication:			Strength:	
Directions for use:				
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:	
Explanation of why the preferred medication(s) would not meet your patient's needs:				
Other Medications tried				
<u>Medications</u>	<u>Strength</u>	<u>Directions</u>	<u>Dates of Therapy</u>	<u>Reason for failure / discontinuation</u>

Physician Signature: _____ **Date:** _____

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