



General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Gender Edit Quantity Edit Age Edit Prior Authorization

Drug Requested _____
(one drug per form only)

Quantity _____
(qty. edit only)

Date: _____

Patient ID#: _____ DOB: _____

Patient Name: _____

Provider NPI: _____

Prescribing Physician: _____

Office Contact: _____

Office Fax #: _____

Office Phone: _____

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*****MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE*****

1. **PROVIDER SPECIALTY** (specify all) _____

2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all) _____

3. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

a. Is the patient currently not compliant on the regimen specific to the diagnosis? Yes No N/A

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL