

Please complete ALL information below and fax your request to 1-888-671-5285

## General Prior Authorization Request Form

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:			Strength:		Dosage Form:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
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)					
<b>Quantity limit requests:</b> What is the quantity requested per DAY? _____ <b>What is the reason for exceeding the plan limitations?</b>					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Patient requires a greater quantity for the treatment of a larger surface area [ <b>Topical applications only</b> ]					
<input type="checkbox"/> Other: _____					

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**  
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