

General Prior Authorization Request Form (Page 1 of 2)

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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 requesting brand			Directions for Use:		
<input type="checkbox"/> 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): _____					
Previous therapies failed. Complete information below or authorization may be delayed:					
Medication Name		Dose		Length of Trial	
1. _____		_____		_____	
2. _____		_____		_____	
3. _____		_____		_____	
Has the patient failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , please describe AND attach chart notes. If incomplete, authorization process will be delayed.					

Quantity limit requests:					
What is the quantity requested per DAY? _____					
Does the patient have a diagnosis of pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , is this cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Previous therapies failed and/or therapies currently used in combination with the requested medication (List ALL medications tried or authorization process will be delayed): _____					

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).					
** Please note: Chart documentation of the above is required to be submitted along with this fax					

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*					
Prescriber Signature: _____			Date: _____		

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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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.