



Please note: All information below is required to process this request.
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



Pancreaze[®], Pertzye[®], Viokace[®] 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 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): _____
Select if the patient has tried and failed at least 30 days of therapy with the following:
<input type="checkbox"/> Creon
<input type="checkbox"/> Zenpep
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: _____

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.