Pharmacy Prior Authorization Request Form

To process this request, please fill out all boxes and attach notes to support the request.

Phone: (844) 782-2678 option 2 Fax: (877) 281-5364

Member information

Member Name	DOB	Date
Member ID #	Sex	Medicine allergies
Pharmacy	Pharmacy phone	
For Injectables only: Facility name	For injectables only: Facility NPI #	
Circle unit of measure Height (in/cm): Weight (lb/kg):		

Prescriber information

Prescriber name	NPI #	DEA #
Prescriber specialty	Prescriber address	
Office fax	Office phone	Office contact name

Medicine requested

Drug name	Strength	Dose	Directions (Sig)
Duration Days: Months:	Quantity	Number of refills	Diagnosis
Is the member currently taking this medicine?			Yes☐ No☐ If yes, how long?

Member's previous medicine(s) related to this request

List previous treatment and outcomes below. Attach a list if there are more than five medicines.				
Drug name	Strength	Dose	Directions	Duration & reason for discontinuing
1				
2				
3				
4				
5				

Medical rationale for request / other clinical Information (diagnostic studies and lab results)

Provider signature:_____ Date of signature:_____