Medication Prior Authorization Request

Prescriber:

One or more of your patient's prescriptions requires prior authorization. Please complete the included prior authorization request form for each medication listed below. You will receive a faxed response to each prior authorization request submitted.

Patient Name:

Date of Birth:

Medication(s):

Prior Authorization Request Form

HIPAA security notice: All information added to this form will be considered current and accurate.

REQUIRED PATIENT INFORMATION			
Patient name:			DOB:
Drug allergies:	Height:	Weight:	Member ID:

REQUIRED PRESCRIBER INFORMATION		
Name:		Specialty:
Address:		
NPI:	Phone:	Fax:

REQUIRED DRUG THERAPY REQUESTED	
Medication name and strength:	
ICD10/Diagnosis:	
Sig:	
Quantity:	Day supply:

REQUIRED CLINICAL INFORMATION	
☐ Continuation of existing therapy: *Please provide chart notes documenting positive clinical response.*	
Initiation Date:	Is the patient currently out of medication? ☐ YES ☐ NO

☐ New therapy: Previous treatments		
Medication and strength	Reason for failure or discontinuation	Dates of therapy

DIAGNOSIS SPECIFIC INFORMATION (WHEN APPLICABLE)		
☐ Most recent A1c value:		Date obtained:
☐ Last HIV test result:		Date obtained:
☐ Result of recent TB test:		Date obtained:
☐ Results of TWO free/total testosterone levels from TWO separate dates		
1. Level:	☐ Free ☐ Total	Date obtained:
2. Level:	☐ Free ☐ Total	Date obtained:

Prescriber Signature: _____ **Date**: _____

Email:MaxCareRx@MaxCareRx.com
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Fax: 1-888-629-9046
Ph: 1-800-259-7765

PO Box 16430
Oklahoma City, OK 73113