



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):

This document complies with (a) applicable Federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. §§3729 et seq.), and the anti-kickback provision of § 1128B of the Act; (b) applicable HIPAA Administrative Simplification Security and Privacy rules at 45 CFR parts 160, 162, and 164; and (c) all other applicable Federal statutes and regulations.

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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	
<input type="checkbox"/> Continuation of existing therapy: <i>Please provide chart notes documenting positive clinical response.</i>	
Initiation Date:	Is the patient currently out of medication? <input type="checkbox"/> YES <input type="checkbox"/> NO

<input type="checkbox"/> New therapy: Previous treatments		
Medication and strength	Reason for failure or discontinuation	Dates of therapy

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

Prescriber Signature: _____ Date: _____