MAXCARE Rx

☐ Standard ☐ Urgent

Prior Authorization Form

Patient Name:			DOB:
☐ Male ☐ Female	Height:	Weight:	Member ID#
Drug Allergies:			Today's Date:
Prescriber's Name			Specialty:
Prescriber's Address			
Prescriber's NPI:		Ph:	Fax:

Medication Requested

Medication Name:		
Strength:	Quantity:	Days:
Sig:		
Anticipated Duration:		
Diagnosis:		

New Therapy

Please include previous treatments, dates, dosing, and reason for failure:

Existing Therapy

Please provide the initiation date:

For renewal of existing therapy, please include the patient's clinical response to therapy:

Important: Please provide applicable laboratory documentation/clinical information

- For the diagnosis of narcolepsy or obstructive sleep apnea, please include sleep study results.
- For the diagnosis of shift work sleep disorder, please include the member's work schedule.
- For the diagnosis of diabetes, please include most recent A1C value.
- For the diagnosis of osteoporosis, please include results of recent bone mineral density scan.
- For initiation of TNF inhibitor medications, please include result of recent TB test.
- For initiation of testosterone therapy, please include TWO free / total testosterone levels.

Prescriber Signature _____Date: _____

Other Relevent Information

Please fax to MaxCare at 888-629-9046 or email maxcarerx@maxcarerx.com
PO Box 16430 Oklahoma City, OK. 73113, Phone: 405-525-5248 / 1-800-259-7765