



### Prior Authorization Request Form

**\*\*\*THIS FORM IS TO BE USED BY PRESCRIBERS ONLY and REQUIRES PRESCRIBER SIGNATURE\*\*\***

**This form is being used for:**

Check all that apply:  Initial Request  Continuation of Therapy/Renewal Request  Request for Compound  
 Other (please specify): \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Member ID#: \_\_\_\_\_ Plan Name: \_\_\_\_\_  
 Requestor's Name & relationship to enrollee (if not patient or prescriber): \_\_\_\_\_

**Prescriber Information:**

Prescribing Clinician: \_\_\_\_\_ Office Phone #: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Office Secure Fax #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medication Information** **Quantity Limit Requests**

Requested Medication: _____ Strength: _____ Dosage Form: _____ Quantity: _____ Day supply: _____ Directions: _____ Diagnosis(es) related to request: _____ ICD-10 Code(s): _____	Please select all that apply: <input type="checkbox"/> Request for titration (Provide titration schedule below) <input type="checkbox"/> Tried and failed plan's quantity limit (Provide rationale below) <input type="checkbox"/> Unable to dose consolidate (Provide rationale below) <input type="checkbox"/> Requested strength/dose not commercially available <input type="checkbox"/> Request is for insulin (Provide TOTAL daily units below) <input type="checkbox"/> Other (please specify): _____
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Brand Request (DAW):  Yes  No  
 If Yes, has the patient had an allergic reaction (e.g., hives/urticaria, rash, anaphylaxis) to at least 1 generic manufacturer?  Yes  No  
 If Yes, has the patient had a non-allergic reaction, therapeutic failure, or side effect with at least 2 generic manufacturers (if available) of the requested drug?  Yes  No  
 If Yes, has a MedWatch form been submitted documenting the therapeutic failure or adverse outcome experienced?  Yes  No

**Clinical Information and History**

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Tried and Failed

**Supporting information such as:** lab values, contraindications, allergies, or any other information relevant to this request.

**Drug Allergies:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_  
**Other:** \_\_\_\_\_

**Urgent (Complete this section ONLY if URGENT):**  
 By signing below, you are attesting that waiting for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function.  
 \_\_\_\_\_ **PRESCRIBER SIGNATURE REQUIRED** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 The Prescriber confirms the above information is accurate and can be verified by patient records.

**Non-Urgent (Complete this section ONLY if NON-URGENT):**  
 \_\_\_\_\_ **PRESCRIBER SIGNATURE REQUIRED** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 The Prescriber confirms the above information is accurate and can be verified by patient records.