Prior Authorization Request Form

Instructions: Please fill out all applicable sections. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Fax completed form to: 469-533-9967

Member Information

Member Name:		Member ID:
Date of Birth:	Gender: ☐ Female ☐ Male	Phone Number:

Provider Information

Provider Name:		Provider NPI#:
Phone:	Fax:	Specialty:

Medication Information

Drug Name:	Strength:	Quantity:	Directions:	Length of Therapy:

Patient diagnosis for use of medication (IC09/10 Codes)

☐ New Therapy ☐ Renewal	Date Therapy Initiated:

Has the patient been seen by any other provider for this condition? ☐ Yes ☐ No

If so, what was the prescriber's specialty:

Previous medications tried and failed for this condition:

Name of Medication:	Strength:	Quantity:	Directions:	Duration & Reason for Discontinuation:

Relevant Clinical Information:

CerpassRx Prior Authorization Department
5904 Stone Creek Drive, Suite 120
The Colony, TX 75056
Phone: 844-636-7506
Fax: 469-533-9967

Attestation: I attest the information provided is true and accurate to the best of my knowledge.

Prescriber Signature: _____ **Date:** _____