

# 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: <input type="checkbox"/> Female <input type="checkbox"/> 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:** \_\_\_\_\_

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