PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Default Question Set (P)

Phone: 1-800-771-4648 Fax back to: 866-552-8939

ELIXIR manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name:	☐ Expedited/Urgent
Directions:	

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Therapy is:

☐ New ☐ Continuation of therapy

Q2. If continuation of therapy, patient has been on therapy for:

☐ Less than 30 days ☐ 30-90 days ☐ More than 90 days

Q3. Diagnosis (provide ICD code):

Q4. Indicate dose and dosing interval:

Q5. Indicate length of therapy being requested:

Q6. List prior failed medications for this diagnosis

Q7. List any concurrent medications that will be used

Q8. Provide any additional information you feel should be considered in determining the benefit status of this medication.

Physician Signature **Date**