FAIRX CLARITY. REDEFINED

Prior Authorization Request Form

SECTION I — REVIEW ***PLEASE COMPLETE AND FAX TO: 866-816-2136*** ***Questions? Call: 833-464-9600***

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or their ability to regain maximum function.

SECTION II — PATIENT INFORMATION

Name: <<MemberFN>> <<MemberLN>>	Member ID#: <<MemberID>>	DOB: <<MemberDOB>>	Phone: <<Phone>>	
Address: <<Address>>	City: <<City>>		State: <<State>>	ZIP Code: <<Zip>>

SECTION III — PRESCRIBER INFORMATION

Name: <<DrName>>		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone: <<PrescriberPhone>>	Fax: <<PrescriberFax>>	Office Contact Name & Phone:		

SECTION IV — DRUG INFORMATION

Requested Drug Name & Strength & Dosage Form: <<Drug>>			
Directions for Use:	Quantity:	Days' Supply:	Expected Therapy Duration:
To the best of your knowledge this medication is: ☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated):_____			
Is brand medically necessary? ☐ Yes ☐ No If Yes, please explain:			

SECTION V — PATIENT CLINICAL INFORMATION

Height:	Weight:	☐ Male ☐ Female
Patient's diagnosis related to this request:		ICD-10 Code:

SECTION VI — RELEVANT LABORATORY OR TEST VALUES AND DATES (attach or list below):

SECTION VII — ALTERNATIVE MEDICATIONS TRIED & REASONS FOR DISCONTINUATION

SECTION VIII — ANY OTHER INFORMATION PRESCRIBER FEELS IS IMPORTANT TO THIS REVIEW

Prescriber Signature : _____Date:_____