

## **Prior Authorization Request Form**

SECTION I — REVIEW PLEASE COMPLETE AND FAX TO: 866-816-2136							Questions? Call: 833-464-9600				
Expedited/Urgent Review	•	•				•		-			
time frame may seriously	/ jeopardize t	the life o	r he	alth of the patien	t or their abil	ity to rega	in maxi	mum func	tion.		
SECTION II — PATIENT INFORMAT	ION										
Name: < <memberfn>&gt; &lt;<memberln>&gt;</memberln></memberfn>		Member ID#: < <memberid>&gt; DOB: &lt;<memberdo< td=""><td colspan="4">&gt;&gt; Phone: &lt;<phone>&gt;</phone></td></memberdo<></memberid>					>> Phone: < <phone>&gt;</phone>				
Address: < <address>&gt;</address>		City: < <city>&gt;</city>					State: < <state>&gt;</state>		ZIP Code: < <zip>&gt;&gt;</zip>		
SECTION III — PRESCRIBER INFOR	MATION										
Name: < <drname>&gt;</drname>			NPI #:					Specialty:			
Address:			City:				State: ZIP Code:				
Phone: < <pre></pre>			>> Office Contact Name & Phone:								
SECTION IV — DRUG INFORMATION	DN										
Requested Drug Name & Stre	ngth & Dosa	ge Form:	: <	<drug>&gt;</drug>							
Directions for Use:				Quantity: Days' Supply: Expe			cted Therapy Duration:				
To the best of your knowledg	e this medica	ation is:									
☐ New therapy ☐	Continuation	of thera	ру	(approximate dat	e therapy init	iated):					
Is brand medically necessary?	P □ Yes	□ No	If	Yes, please expla	in:						
SECTION V — PATIENT CLINICAL II	NFORMATION										
Height:				Weight:				☐ Male ☐ Female			
Patient's diagnosis related to this request:							ICD-10 Code:				
SECTION VI — RELEVANT LABORA	TORY OR TES	Γ VALUES	ANI	D DATES (attach or	list below):						
SECTION VII — ALTERNATIVE MED	NICATIONS TRI	FD & REA	SOI	NS FOR DISCONTINI	IATION						
SECTION VIII ALTERNATIVE VIEW	TEATIONS TH	LD Q KL	1501	15 TON DISCONTINU	Allon						
SECTION VIII — ANY OTHER INFO	RMATION PRE	SCRIBER	FEEI	S IS IMPORTANT TO	THIS REVIEW	1					
Prescriber Signature :						Dat	:e:_				

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