Updated 2/21/2022

10181 Scripps Gateway Court
San Diego, CA 92131

Kroger Prescription Plans

Fax: (858) 790-7100

Prior Authorization Request Form

This form **is to be used by prescribers only**

This form is being used for:

Check one: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request

Reason for request *(check all that apply)*: ☐ Prior Authorization ☐ Formulary Exception ☐ Quantity Exception
☐ Compound Formulary Exception ☐ Copay Tier Exception ☐ Step Therapy Exception
☐ Other *(please specify)*: _____

Patient Information

Patient Name:	DOB:	Phone#:	
Drug Allergies:	Height/Weight:	Gender: ☐ Male ☐ Female	
Address:	City:	State:	Zip:
Member ID #:	Plan Name:		
Requestor's Name & relationship to enrollee (if not patient or prescriber):			

Prescriber Information

Prescribing Clinician:	Office Phone #:		
Specialty:	Office Secure Fax #:		
NPI #:	DEA/xDEA:		
Address:	City:	State:	Zip:
Contact Person (if different than provider):			
Prescriber's or Authorized Representative's Signature:		**Date:**	

Medication Information

Requested Medication:

Strength: Quantity: Directions:

Diagnosis(es) related to this request:

ICD-10 Code(s):

**Brand name medication will only be approved for medical exceptions; generic copay overrides will be considered on a case-by-case basis

Is the request for a Brand Override due to Manufacturer Copay Card? ☐ Yes ☐ No

If yes, would the generic medication be appropriate at a reduced cost? ☐ Yes ☐ No

Is the request for BRAND ONLY for a medical reason? ☐ Yes ☐ No

If yes, please document three dates of previously tried and failed therapies below or provide documentation why the brand is medically necessary:

Previous Therapies Tried and/or Failed

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Failure

Additional information related to this request (lab values, non-pharmacologic therapies, contraindications, risk vs benefits, explanations for exceptions/continuation of current treatment):

If applicable, does the prescriber acknowledge or is aware that The American Geriatrics Society (AGS) considers the requested medication to be of high risk for patients 65 years old or older? ☐ Yes ☐ No

Is the patient currently enrolled in HOSPICE? ☐ Yes ☐ No

If yes, is the requested medication being used for an indication UNRELATED to the terminal illness(es)/ condition(s)? ☐ Yes ☐ No

☐ By checking this box, I attest this is an *urgent case*, meaning that an expedited (fast) determination is necessary to prevent serious threat to life, health or the body's ability to regain maximum function; or is needed to manage severe pain.

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA