MAXORplus
PHARMACY BENEFIT MANAGEMENT SERVICES

Prior Authorization Drug Request

IMPORTANT INFORMATION REQUIRED -
FORM CANNOT BE PROCESSED WITHOUT REQUIRED DOCUMENTATION.

A separate request must be completed for each drug for each patient.

Date: _____ **Office Nurse/Manager:** _____

Prescriber: _____ **Office Phone#:** _____

Client: _____ **Office Fax#:** _____

Group: _____

Patient: _____ **DOB:**_____

Member #: _____ **Drug Name:** _____

MaxorPlus Comments: The above patient has a prescription for a medication which requires a prior authorization. This drug will be prior authorized if all the criteria have been met. Please indicate the diagnosis, other treatments tried and any information relevant to the review of this request below and fax the form back to us as instructed.

Dosage: _____ **Directions for use:** _____

Quantity: _____ **Anticipated duration of therapy:** _____

Diagnosis: _____

ICD-9 Code(s):_____

Indication: _____

Prior alternative treatment(s) provided for this condition: _____

_____

Required Supporting Clinical Statement (such as protocols or evidence based guidelines followed, concurrent therapies, comorbities, outcomes of previous drugs and therapies used, etc.):

_____

_____

Relevant Lab Values: _____

Prescriber Signature / Date: _____

Fax toll free to **844-370-6203** or mail to: MaxorPlus, 320 S. Polk, Suite 200, Amarillo, TX 79101
You will be notified within 24-48 hrs whether the request was approved. For inquiries, call 800-687-0707.

This form contains protected health information and is subject to all privacy and security regulations under HIPAA.