medOne Pharmacy Benefit Solutions

**FAX COMPLETED FORM TO:**

**1-888-344-6011**

**QUESTIONS PLEASE CALL:**
**1-888-884-6331**

Prescription Drug Prior Authorization Form

# Standard Form

Prescriber Name: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

Patient Name: _____ Patient ID #: _____

DOB: _____ Date: _____

*******************FAILURE TO COMPLETE FORM MAY RESULT IN AUTOMATIC DENIAL*******************

Drug Name: _____

Strength: _____

Directions: _____

Duration of Therapy: _____

Indication: _____

Diagnosis Code: _____

## ***Chart Notes from Physician Required to Document Failure in Order to Override Benefit***

**Complete the Following for Previous Treatment(s) for the Same Condition:**

| Treatment/Drug Used | Date(s) Used | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Prescriber Comments:** _____

**Prescriber Signature or Name/Title of Staff Member:** _____