



## PRIOR AUTHORIZATION REQUEST FORM

Please e-mail this request to [priorauth@pdm.com](mailto:priorauth@pdm.com)

### Patient Information:

PATIENT NAME: (LAST, FIRST)	DOB: (MM/DD/YYYY)	AGE:	SEX:
PATIENT PHONE:	MEMBER ID; PERSON CODE		
MEDICAL INSURANCE:	GROUP NAME:	GROUP NO.	
PHARMACY NAME/ADDRESS:	PHARMACY PHONE:		

### Physician Information:

PRESCRIBER'S NAME	NPI NUMBER	CONTACT PERSON
ADDRESS	PHONE	FAX

### Medication Request:

DIAGNOSIS/INDICATION				ICD-9 or ICD-10 CODE	
DRUG NAME & STRENGTH		SIG	QTY	DAYS SUPPLY	REFILLS
DATE PRESCRIBED	DURATION OF THERAPY		NEW THERAPY <input type="checkbox"/> YES <input type="checkbox"/> NO		
LAST EVALUATION DATE (mm/dd/yyyy)			NEXT APPOINTMENT DATE (mm/dd/yyyy)		
Medical Justification for this condition- Include Laboratory, Physical exam findings, as applicable (attach additional information, if needed). <i>Specify <u>any associated risk factors</u> with the following indications-</i>					
<input type="checkbox"/>					
<input type="checkbox"/>					
1- PREVIOUS MEDICATION/TREATMENT			2- PREVIOUS MEDICATION/TREATMENT		
REASON FOR DISCONTINUATION:			REASON FOR DISCONTINUATION:		
3- PREVIOUS MEDICATION/TREATMENT			4-PREVIOUS MEDICATION/TREATMENT		
REASON FOR DISCONTINUATION:			REASON FOR DISCONTINUATION:		

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