PDMI

PRIOR AUTHORIZATION REQUEST FORM

Please e-mail this request to priorauth@pdmi.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 ☐ YES ☐ 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). *Specify <u>any associated risk factors</u> with the following indications-* ☐ ☐				
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:		