PRO ACT
PHARMACY BENEFIT MANAGEMENT

Request Type: ____ Standard
____ Urgent

Prior Authorization Request Form

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129
EOC ID:

Prior authorization requests should be submitted via our online portal at proactrx.promptpa.com. Here providers can perform medication-specific requests and submit reauthorizations and/or appeals.

Electronic submissions are encouraged. If needed requests, and supporting documentation, may be faxed to 1-844-712-8129.

Please visit www.proactrx.com/resource-pages/drug-lists to see products included in quantity limit, prior authorization, or step therapy programs. Product list may not be all inclusive based on differing plan designs.

Member Information (required)

Member Name:		
Insurance ID#:		
DOB:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Qty:	Days Supply:
❑ Check if requesting **brand**	Directions for Use:		
❑ Check if request is for **continuation of therapy**			

Clinical Information (required)

Proactive Benefit Review:
❑ Check if this is a proactive request for a benefit determination

What is the patient's diagnosis for the medication being requested?

Diagnosis (Written and ICD-10 Code(s)): _____

What medication(s) has the patient tried and failed?

Are there any supporting labs or test results? (Please specify)

PRO ACT
PHARMACY BENEFIT MANAGEMENT

Request Type: ____ Standard
____ Urgent

Prior Authorization Request Form

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received. In addition, plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:			**EOC ID:**
Clinical Review Decision			
	Date:		
	☐	**Approved, through:**	
	☐	**Denied**	