**CONFIDENTIAL**

SCRIPT CARE, Ltd.

SCL Clinical Staff manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Answer the following questions and fax this form to the number listed below within <<replydays>> business days or the request will be automatically denied. Please note any information left blank or illegible may delay the review process.

# Clinical Prior Authorization Request Form
# Fax back to this number 888-518-7328

| | | | |
|---|---|---|---|
| Patient | **patient_first_name patient_last_name** | Provider | **prescriber_name** |
| Patient ID | **patient_id** | Provider Phone | **prescriber_phone** |
| DOB | **patient_date_of_birth** | Provider Fax | **prescriber_fax** |
| Address | **patient_address** | Provider Email | **prescriber_email** |
| City, State Zip | **patient_city, patient_state, patient_zip** | Group Name | **group_name** |
| Ticket Number | **ticket_number** | Group Number | **group_number** |

Drug: **drug_drug_name**
Requested Quantity or Units: **drug_quantity**
Requested Day Supply: **drug_supply**

**Please provide or attach any additional supporting medical history or clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional information) to support this request. Please answer the following questions and sign:**

**1. Please indicate the patient's diagnosis as it relates to this medication (ICD code plus description).**

**2. What type of therapy is the medication being requested for?**

◯ Initial Therapy

◯ Continuing Therapy **(If continuing therapy, submit documentation of positive response to avoid delay in review and skip to Q4.)**

**3. What other medications have been tried and failed?**

◯ Drug and Strength:_____ Frequency:_____ Period of Use:_____ to_____

◯ Drug and Strength:_____ Frequency:_____ Period of Use:_____ to_____

◯ Drug and Strength:_____ Frequency:_____ Period of Use:_____ to_____

◯ Drug and Strength:_____ Frequency:_____ Period of Use:_____ to_____

◯ None

4. **If continuing therapy, how long has the patient been on this medication?**

- ◯ Less than 1 month
- ◯ 1 month to 6 months
- ◯ 6 months to 1 year
- ◯ 1 year or greater

5. **What is the anticipated duration of this medication and therapy?**

- ◯ One time only
- ◯ Less than 1 month
- ◯ 1 month to 6 months
- ◯ 6 months to 1-year
- ◯ Lifetime

6. **Please provide any additional information that should be considered:**

**Physician Signature** **Date**

**Ticket Number: ticket_number**