

CONFIDENTIAL



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

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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

