

# Prior Authorization Request



Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit [ServeYouRx.com](https://ServeYouRx.com) or call 800-759-3203.

**Note:** Blank fields or illegible responses may delay the review process. **Fax completed form to:** 800-480-4840 Attn: Authorizations

You may also email to [PriorAuthorizations@ServeYouRx.com](mailto:PriorAuthorizations@ServeYouRx.com) or mail to:  
Serve You Rx, Attn: Authorizations, 10201 West Innovation Drive, Suite 600, Milwaukee, WI 53226

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Permanent Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_  
 Mobile  Work  Home  Mobile  Work  Home

## PRESCRIBER INFORMATION

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
NPI: \_\_\_\_\_ State License ID: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

## REQUESTED MEDICATION

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_ If this is a continuation of therapy, provide start date: \_\_\_\_\_

## CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ Diagnosis Code (ICD): \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_

List all medications the patient has previously tried and failed for treatment of this diagnosis including reason(s) for discontinuation and provide all relevant clinical documentation that supports use of this medication. If a continuation of therapy, provide documentation of clinical improvement or significant clinical response.

- Pertinent medical history or information for this patient is attached that may support approval  
 Urgent review requested

## SIGNATURE

Prescriber's Signature: \_\_\_\_\_ Today's Date (month/day/year): \_\_\_\_\_

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.

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