

GENERAL AUTHORIZATION FORM
Prior Authorization, Step Therapy & Quantity Limit Exception

<input type="checkbox"/> Standard Request <input type="checkbox"/> Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision.
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Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female	NPI#:	Specialty:
Pharmacy Benefits ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Frequency:
Quantity Dispensed:	Day Supply:	<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.
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Billing Information

<input type="checkbox"/> Billed by PHARMACY delivered to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Diagnosis:	Date Diagnosed:
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History of Medications Used to Treat Above Condition

<input type="checkbox"/> No other medications have been used to treat this condition					
Medication	Strength	Frequency	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____

Date: _____

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