Prior Authorization Form

300 Corporate Parkway
Amherst, NY 14226
Toll Free **1.800.830.2310** Fax **763.582.3477**

URGENT ▭ STANDARD ▭ (TURN AROUND TIME: URGENT IS 72 BUSINESS HOURS AND STANDARD IS 15 BUSINESS DAYS)

Rx General Form	Date:
Cardholder Employer (Company Providing Health Benefits):	
PATIENT INFORMATION	
Patient Name:	Date of Birth:
ID#:	Patient Phone:
Mailing Address:	
PROVIDER INFORMATION	
Provider Name:	Provider Signature:
Office Contact Person:	
Office Phone:	Office Fax:
PRIOR AUTHORIZATION FORM	
Medication:	Quantity/Day Supply
Diagnosis: (ICD-9): **Please provide clinical documentation to support request (Letter of Medical Necessity, Lab Results, Chart Notes, Peer Review Literature, Clinical Trial Results/Findings, etc.)**	
Duration of therapy:	
History of failed drug therapies (include drug name, strength and duration):	
Additional Information:	

Fax Completed Form and Supporting Documentation to: 763.582.3477

Notification to Physician• Meritain Health Pharmacy Solutions (MPS) will notify the requesting physician with a return fax to the same number where the fax originated (PHI secure)

☐ **APPROVED** - Plan will cover this medication through Date: ___________________

☐ **DENIED** - Plan will not cover this medication (see attached)

☐ **EXCLUDED** - Plan does not cover this medication (Medication is excluded from coverage by the plan)

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