PRIOR AUTHORIZATION REQUEST FORM

EOC ID: «EOC ID»

«Product Name»

Fax back to: 1-866-404-1771

Southern Scripts manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: «Patient Name»	**Prescriber Name: «Prescriber Name»**
Member/Subscriber Number: «Member Id»	Fax: «Prescriber Fax1» Phone: «Prescriber Phone»
Date of Birth: «Patient DOB»	Office Contact:
Group Number: «Group Number»	NPI: «Prescriber NPI» State Lic ID:
Address: «Patient Address Line 1» «Patient Address Line 2»	Address: «Prescriber Address Line 1» «Prescriber Address Line 2»
City, State ZIP: «Patient City» «Patient State» «Patient Zip»	City, State ZIP: «Prescriber City» «Prescriber State» «Prescriber Zip»
Primary Phone: «Patient Phone Number»	Specialty/facility name (if applicable):

☐ Expedited/Urgent

Drug Name and Strength: «HCS Name»

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

«Clinical Questionnaire (blank)»

_____ _____

Prescriber Signature Date