

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Fax completed form to **888.610.1180**

Electronic version available at <https://rxb.promptpa.com>

**Incomplete form will delay the coverage determination. Please fill out all sections completely and legibly.
Documentation is required for all requests.**

Request Date:				<input type="checkbox"/> Request to expedite review
<i>If the prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, please mark above the request to expedite this review process.</i>				
Patient Information				
This section must be filled out completely to ensure HIPAA compliance				
First Name:		Last Name:		Phone Number:
Address:			City:	State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Member ID:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:	
Prescriber Information				
First Name:		Last Name:		Specialty:
Address:			City:	State: Zip Code:
NPI Number (individual):			Phone Number:	
Fax Number (in HIPAA compliant area):				
Dispensing Pharmacy Information				
Pharmacy Name:			Pharmacy Fax Number (in HIPAA compliant area):	
Medication and Medical Information				
Medication Name and Strength:			<input type="checkbox"/> Dispense as written <input type="checkbox"/> Generic substitution permitted* <i>*default is generic substitution permitted</i>	
Directions for Use:			Quantity:	Day Supply:
<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuation of Therapy - Start Date: _____		Duration of Therapy:	
ICD 10 codes(s) and diagnosis for use of medication:		Patient Height (in/cm):	<input type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit	
		Patient Weight (lb/kg):		
If the patient has tried other medication(s) for this condition, please provide a list of previously tried and failed agents, including dates and reason(s) for failure				
Has documentation (i.e., chart notes, pertinent lab values, medical history, etc.) been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Prescriber attests that the provided information is complete and accurate and understands that RxBenefits, Inc. reserves the right to perform an audit requesting the medical information necessary to verify accuracy at any time.				
Prescriber Signature: _____			Date: _____	
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