PRIOR-AUTHORIZATION FORM- GENERAL

Patient Information	
Member's name	
Member's ID number	
Member's telephone number	
Prescriber Information	
Physician's name	
Physician's medical specialty	
Physician's telephone number	
Pharmacy Information	
Pharmacy's name	
NPI number	
Pharmacy's telephone number	

Please provide all requested information. Incomplete forms will be returned. Prescription copy is required for evaluation.

MEDICATION REQUESTED: _____

DURATION OF TREATMENT: _____

DIADNOSIS: _____

REASON FOR REQUEST: _____

_____

_____

_____

_____

_____

PREVIOUSLY USED MEDICATIONS FOR CONDITION: _____

_____

_____

Printed Name: _____ Signature: _____

Please specify contact's person name (if different from above): _____

For PharmPix use:

Date received _____ Date reviewed _____ By (initials) _____

Approved/Denied _____ Notification Date _____ By (initials) _____

CHANGING THE WAY PBMs WORK, NOW AND FOR EVER