

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:	rinted Name: Signature: Signature:	
Please specify contact's person na	me (if different from above):	
For PharmPix use:		
Date received	Date reviewed	By (initials)
Approved/Denied	Notification Date	By (initials)
The information transmitted is intended only for the	person or entity to which it is addressed and m	ay contain lawyer/client and/or corporate, privileged confidentia

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