pharmpix
POWERED BY ONEARK

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: ____________________

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PREVIOUSLY USED MEDICATIONS FOR CONDITION: ____________________

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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)	________

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