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Prior-Authorization Request Form – General

Patient Information			
Member Name			
Member ID number		Height / Date	
Member Telephone		Weight / Date	
Prescriber Information			
Physician Name			
Physician Specialty			
NPI Number			
Physician Telephone			
Pharmacy Information			
Pharmacy Name			
NPI Number			
Pharmacy Telephone			
Prescription information			
Name of the medication		Potency	
Instructions		Date of prescription	
Is this a new therapy or renewal?		Quantity	

Please provide all requested information. Incomplete forms will be returned. Prescription copy is required for evaluation. Please attach any other document supporting the request.

Patient's diagnosis: ____

Reason for request (If the medication is been requested for an off-label use, submit documentation to support the off-label use):

____
____
____
____

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Previously used medication(s) for condition (If applicable):

____
____
____

Medication(s) to be used concurrently (If applicable):

____
____
____

Absence of contraindication(s) has been confirmed by the prescriber physician?
_____Yes _____No

Printed Name: ____________________________________ Signature: _______________________

Please specify Contact Person Name (if different from above): __________________________________

For PharmPix use:

Date reviewed___________________ By (initials) __________________________

Approved/Denied________________ Approval Expiration Date_______________

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