PharmPix Standard Prior Authorization Request Form for Prescription Drug Benefits

Please read all instructions below before completing this form.

Please fax to 866-912-3052.

Intended Use: Use this form to request authorization by fax or mail when PharmPix requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:
Section I – Submission:
Includes name and contact information for PharmPix.

Section VI – Prescription Compound Drug Information:
List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information:
Enter ICD Version 9 or 10, as applicable.

Section IX — Justification:
In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable.

Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *We may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please call 1-855-882-7499 before faxing or mailing your request.*

pharmpix
POWERED BY ONEARK

PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

Clear Form | Print

SECTION I — SUBMISSION

Submitted to: PharmPix	Phone: 1-855-882-7499	Fax: 1-866-921-3052	Date:

SECTION II — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

SECTION IV — PRESCRIBER INFORMATION

Name:	NPI #:	Specialty:	
Address:	City:	State:	ZIP Code:
Phone: / Fax:	Office Contact Name:	Contact Phone:	

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:

Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: _____)

For Provider Administered Drugs Only:

HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge) Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)
