Medication Prior Authorization Request Form

**REQUIRED FIELDS: PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.*

Type of Request:

Today's Date: _____

I. MEMBER INFORMATION	II. PRESCRIBER INFORMATION
***Name:**	***Name:**
ID Number:	Specialty:
Gender:	***NPI or DEA Number:**
***Date of Birth:**	***Phone:**
Medication Allergies:	***Fax:**
Member's Height:	Office Contact Name:
Member's Weight: ◯kg ◯lb. (select one)	

III. ADMINISTRATION

Site of Administration: If other, specify:

If preferred administration site has a different address than the prescribing physician's practice above, please complete the following:

Name of Preferred Site of Administration or Home Infusion Company:

Contact Name: Phone: Fax: NPI#:

IV. DRUG INFORMATION (only ONE drug request per form)	
***HCPCS (if buy and bill):**	***Drug Name:**
***Strength:**	***Dosage Form:**
***Directions for Use (sig):**	
***Therapy Start Date:**	***Therapy End Date:**

V. DIAGNOSIS (as relevant to this request)	
Diagnosis:	***ICD10:**
Date of Diagnosis:	NOTE: Include diagnostic clinicals (labs, radiology, etc.).

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.

X _____ **Date:** _____

Prescriber Signature

For a current listing of preferred products, visit SunshineHealth.com or contact Provider Services at 1-844-477-8313.