

Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.



- PLEASE** {
- Complete this form and fax to the number listed under the logo.
 - Not any information left blank or illegible may delay the review process.
 - Use one form per medication prior authorization request.

Phone: 1-877-935-8022
 Prior Auth Fax: 1-877-617-0394

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI/DEA Number:	
Address:		Facility Name:	
City, state, Zip:		Address:	
Group Number:		City, state, Zip:	
III. MEDICATION REQUESTED			
Drug Name:			
Directions/SIG:			
Quantity:			
J-Code (if applicable):			
IV. ADDITIONAL CLINICAL INFORMATION			
ICD-9 Code:			
Diagnosis:			
Is the medication being requested for use in an ongoing investigational trial? <input type="checkbox"/> Yes <input type="checkbox"/> No			
V. MEDICATION HISTORY (for this diagnosis)			
list therapeutic alternatives previously used with start/end dates and outcomes:			
Drug Name, strength, and Dosage	Dates of Therapy	Reason for Discontinuation	
1			
2			
3			
VI. PERTINENT CLINICAL INFORMATION			
NOTE: Please attach any pertinent medical history or information for this patient that may support approval			

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

STANDARD REVIEW

Prescriber Signature

Prescriber Signature

_____ Date: _____

_____ Date: _____