



FAX COMPLETED FORM TO:
1-888-344-6011
QUESTIONS PLEASE CALL:
1-888-884-6331

Prescription Drug Prior Authorization Form
Standard Form

Prescriber Name:	Prescriber NPI:
Prescriber Phone:	Prescriber Fax:
Patient Name:	Patient ID #:
DOB:	Date:

*****FAILURE TO COMPLETE FORM MAY RESULT IN AUTOMATIC DENIAL*****

Drug Name: _____

Strength: _____

Directions: _____

Duration of Therapy: _____

Indication: _____

Diagnosis Code: _____

*****Chart Notes from Physician Required to Document Failure in Order to Override Benefit*****

Complete the Following for Previous Treatment(s) for the Same Condition:

Treatment/Drug Used	Date(s) Used	Results

Prescriber Comments: _____

Prescriber Signature or Name/Title of Staff Member: _____

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