Plan/Medical Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fax# (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes of lab data, to support the prior authorization request. |
| **Patient Information: This must be filled out completely to ensure HIPAA compliance** |
| First Name : Last Name: MI: Phone#: ( ) |
| Address: City: State: Zip Code: |
| Date of Birth : 🗖Male 🗖Female Height : weight:  |
| Allergies: |
| Patient’s Authorized Rep (If applicable) Phone Number# ( ) |
| **Insurance Information** |
| Primary Insurance Name: ID Number:  |
| Secondary Insurance Name: ID Number:  |
| **Prescriber Information** |
| First Name :  | Last Name  |  NPI# DEA# |
| Address: City : State: Zip Code  |
| Office Contact Person: Phone # Fax #   |
| Email Address   |
| **Medication / Medical and Dispensing Information** |
| Medication Name:  |
| 🗖New Therapy 🗖Renewal If Renewal date therapy Initiated: Duration of Therapy (specific dates) |
|  How did the patients receive their medication?🗖 Paid under insurance  Name of Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior Auth #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗖 Other ( Please Explain)  |
| Dose/ Strength: | Frequency:  | Length of Therapy/ # of refills | Quantity:  |
|   |
|  Administration:🗖 Oral/SL 🗖Topical 🗖Injection 🗖IV 🗖Other |
|  Administration Location : 🗖Patient’s Home 🗖Long Term Care 🗖 Physician’s Office 🗖 Home Care Agency 🗖 Other (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_🗖Ambulatory Infusion Center 🗖 Outpatient Hospital Care  |
| Patient Name:  | ID# |
| Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes of lab data, to support the prior authorization request. |
|  1. Has the patient tried any other medication for this condition? 🗖 YES ( if yes complete below) 🗖 No  |
| Medication / Therapy(specify Drug Name & Dosage) | Duration of Therapy(Specify Dates) | Response/Reason For Failure/Allergy |
| 2. Last Diagnoses: | ICD-9/ ICD-10: |
|   |  |
|  3. Required Clinical Information- Please provide all relevant clinical information to support a prior auth review : |
|  Please provide symptoms, lab results with dates & justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lad results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws. 🗖Attachments |
| Attestation: I attest the information provided is true and accurate to the best of my knowledge. I Understand that the health plan, insurer Medical Group of its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information report on this form.Prescriber Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
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| Plan Use Only: Date of Decision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🗖Approved 🗖 Denied Comments/Information Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |