Prior Authorization Request Form

**Member Information** (required) | **Provider Information** (required)
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Member Name: | Provider Name: |
Insurance ID#: | NPI#: |
Date of Birth: | Specialty: |
Street Address: | Office Phone: |
City: | State: |
Phone: | Zip: |

**Medication Information** (required)

Medication Name: |
Strength: |
Dosage Form: |

- Check if requesting **brand** |
- Check if request is for **continuation of therapy** |

Is the physician supplying the medication?  Yes  No

**Clinical Information** (required)

What is the patient’s diagnosis for the medication being requested?

ICD-10 Code(s): __________________________

What medication(s) has the patient tried and failed?

Are there any supporting labs or test results? (Please specify)

**Quantity limit requests:**
What is the quantity requested per **DAY**? __________

**What is the reason for exceeding the plan limitations?**
- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Patient requires a greater quantity for the treatment of a larger surface area [**Topical applications only**]
- Other: __________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

________________________________________________________________________________________________________________

**Please note:** This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.