



Prior Authorization Request Form

THIS FORM IS TO BE USED BY PRESCRIBERS ONLY and REQUIRES PRESCRIBER SIGNATURE

This form is being used for:

Check all that apply: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request ☐ Request for Compound
☐ Other (please specify): _____

Patient Information:

Patient Name: _____ DOB: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Member ID#: _____ Plan Name: _____
Requestor's Name & relationship to enrollee (if not patient or prescriber): _____

Prescriber Information:

Prescribing Clinician: _____ Office Phone #: _____
Specialty: _____ Office Secure Fax #: _____
NPI #: _____ DEA: _____
Address: _____ City: _____ State: _____ Zip: _____

Medication Information

Quantity Limit Requests

Requested Medication: _____	Please select all that apply: ☐ Request for titration (Provide titration schedule below) ☐ Tried and failed plan's quantity limit (Provide rationale below) ☐ Unable to dose consolidate (Provide rationale below) ☐ Requested strength/dose not commercially available ☐ Request is for insulin (Provide TOTAL daily units below) ☐ Other (please specify): _____
Strength: _____ Dosage Form: _____	
Quantity: _____ Day supply: _____	
Directions: _____	
Diagnosis(es) related to request: _____	
ICD-10 Code(s): _____	

Brand Request (DAW): ☐ Yes ☐ No

If Yes, has the patient had an allergic reaction (e.g., hives/urticaria, rash, anaphylaxis) to at least 1 generic manufacturer? ☐ Yes ☐ No

If Yes, has the patient had a non-allergic reaction, therapeutic failure, or side effect with at least 2 generic manufacturers (if available) of the requested drug? ☐ Yes ☐ No

If Yes, has a MedWatch form been submitted documenting the therapeutic failure or adverse outcome experienced? ☐ Yes ☐ No

Clinical Information and History

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Tried and Failed

Supporting information such as: lab values, contraindications, allergies, or any other information relevant to this request.

Drug Allergies: _____

Height: _____

Weight: _____

Other: _____

☐ Urgent (Complete this section ONLY if URGENT):

By signing below, you are attesting that waiting for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function.

PRESCRIBER SIGNATURE REQUIRED

Date: _____

The Prescriber confirms the above information is accurate and can be verified by patient records.

☐ Non-Urgent (Complete this section ONLY if NON-URGENT):

PRESCRIBER SIGNATURE REQUIRED

Date: _____

The Prescriber confirms the above information is accurate and can be verified by patient records.