



### General Prior Authorization Form

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Gender Edit     Quantity Edit     Age Edit     Prior Authorization

**Drug Requested** \_\_\_\_\_  
(one drug per form only)

**Quantity** \_\_\_\_\_  
(qty. edit only)

**Date:** \_\_\_\_\_

**Patient ID#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Provider NPI:** \_\_\_\_\_

**Prescribing Physician:** \_\_\_\_\_

**Office Contact:** \_\_\_\_\_

**Office Fax #:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

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**\*\*\*MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE\*\*\***

**1. PROVIDER SPECIALTY** (specify all) \_\_\_\_\_

**2. DIAGNOSIS FOR DRUG REQUESTED** (specify all) \_\_\_\_\_

**3. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

a. Is the patient currently not compliant on the regimen specific to the diagnosis? |  Yes  No  N/A

Please add any other supporting medical information that may be useful in the decision-making process:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

<b>Internal use only</b>	<b>Coverage effective date</b> / /
Document # _____	Processor Initials _____ Date _____
M    F    Rx coverage    Y    N	STANDARD - SELECT    LOB _____
Previous Auth    Y    N	<b>Approved</b> <b>Reviewer Initials</b> _____ <b>Date</b> _____