Please complete ALL information below and fax your request to 1-888-671-5285

General Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested (specify all)?

_____

ICD-10 Code(s): _____

Is the requested medication being used to treat the patient's stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer? ❑ Yes ❑ No

Medication history (Please list any previous or current therapy related to the diagnosis, using drug names and dates):

Drug Name (dose & frequency)	Duration of therapy (include dates)	Currently prescribed
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

_____

_____

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Is there documentation of the inability to reach the requested dose with higher strengths of commercially available dosage forms due to patient specific characteristics (i.e. inability to swallow larger pills, malabsorption, presence of a feeding tube, etc.)? **❑ Yes ❑ No**

Is the requested dose commercially available? **❑ Yes ❑ No**

Is there documentation the dose requested is medically necessary? **❑ Yes ❑ No**

If YES, please specify: _____

_____

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.