

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

General Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> 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
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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