Prescription Drug Prior Authorization Request Form

MEMBER INFORMATION

LAST NAME:

FIRST NAME:

MEMBER ID NUMBER:

DATE OF BIRTH: - -

PHONE NUMBER: - -

PROVIDER INFORMATION

LAST NAME:

FIRST NAME:

NPI NUMBER:

SPECIALTY: _____

STREET ADDRESS:

CITY: STATE: ZIP:

PHONE NUMBER : - -

FAX NUMBER : - -

DRUG INFORMATION

MEDICATION:

DRUG: _____ STRENGTH: _____

DIRECTION OF USE: _____

DIAGNOSIS: _____

DATE PATIENT STARTED MEDICATION (IF PREVIOUSLY STARTED): _____

NAME OF SPECIFIC MEDICATION(S) TRIED AND FAILED:

_____

REASON FOR NON-FORMULARY REQUEST, AND/OR CLINICAL JUSTIFICATION FOR REQUESTED DRUG USE:
(PLEASE INCLUDE RELEVANT LAB VALUES WHEN APPROPRIATE. NOTE: PATIENT CHART NOTES WILL BE REQUESTED IF FURTHER DOCUMENTATION IS NECESSARY.)

_____

ADDITIONAL NOTES:

_____

_____ _____

Prescriber's Signature (Required) Date

Please fax this completed form to Medical Associates Health Plan/Health Choices/Live360 at **563-584-4778**.

Questions? Please call 866-821-1365

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