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

012323M