

PLEASE FAX THIS REQUEST FORM TO 1-844-857-7374 (toll-free)

The prescriber must complete this form in full to avoid processing delay. Please attach any information that should be considered with this request.

PATIENT INFORMATION

Patient Name		Date of Birth	Gender: M/F	
Address	City		State	Zip
Member ID	Height		Weight	
Medication Allergies				

PRESCRIBER INFORMATION

Prescriber Name		NPI Number	DEA/Licensing Number	
Prescriber Specialty	Clinic Name			
Prescriber Address	City		State	Zip
Office Phone	Office Fax	Office Contact Name		
Pharmacy	Pharmacy Phone	Pharmacy Fax		

MEDICATION REQUESTED

Drug Name and Strength		Directions		
Quantity	Start Date (mm/dd/yy)	Diagnosis	ICD-9/ICD-10	
Reason for Authorization Request (Leave blank if unknown)				
<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Step Therapy <input type="checkbox"/> Quantity Limit override <input type="checkbox"/> Other _____				

MEDICAL JUSTIFICATION: Include Other Relevant Medications Tried and Results

Previous Medication	Strength	Directions	Dates (mm/yy to mm/yy)	Reason for Discontinuation
1.				
2.				
3.				
4.				

RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION (Attach Relevant Lab Results and Chart Notes)

Provider Signature	Date
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PLEASE FAX THIS REQUEST FORM TO CLEARSCRIPT AT 1-844-857-7374

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