

**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	
<b>Reason for Authorization Request (Leave blank if unknown)</b>				
<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)**

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

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