Authorization Request Form

ClearScript℠

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)

□ Prior Authorization □ Step Therapy □ Quantity Limit override □ 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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