

# Authorization Request Form

**PLEASE FAX THIS REQUEST FORM TO 1-855-875-7443 (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)

Provider Signature	Date

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