



General Specialty Medication PA Form Prior Authorization Form/ Prescription

Date: _____ Date Medication Required: _____
Ship to: ☐ Physician ☐ Patient's Home ☐ Other _____

Phone: 1-866-399-0928 Fax: 1-833-645-2742

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/____
Address:		City:	State: Zip:
Daytime Phone:	Evening Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Insurance Information (Attach copies of cards.)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:
Address:		City: State: Zip:
Phone # ()	Secure Fax #: ()	Office contact:

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Primary Diagnosis

Primary ICD-10 Code: _____

Description in words: _____

Clinical Information ***** Please submit supporting clinical documentation*****

☐ INITIAL THERAPY ☐ CONTINUATION OF THERAPY Therapy start date: _____

Patient's weight _____ kg Patient's height _____ inches

1. Is the member currently treated with this medication? ☐ Yes ☐ No
2. If continuation of therapy, how long has the patient been on treatment? _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐ Yes ☐ No
4. Please indicate previous treatment and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria.

5. Please state Rationale for Request / Pertinent Clinical Information (**Required for all prior authorizations.**)

Physician's Signature _____ Date: _____ ☐ DAW