# PREVENTATIVE MEDICATION & PRIOR AUTHORIZATION REQUEST FORM

## Patient Information:

| PATIENT NAME: (LAST, FIRST) | DOB: (MM/DD/YYYY) | AGE: | SEX: |
|---|---|---|---|
| PATIENT PHONE: | MEMBER ID; PERSON CODE | | |
| MEDICAL INSURANCE: | GROUP NAME: | GROUP NO. | |

## Physician Information:

| PRESCRIBER'S NAME | SPECIATLY<br>ENT | CONTACT PERSON |
|---|---|---|
| ADDRESS | PHONE | FAX |

## Medication Request:

| DIAGNOSIS/INDICATION | | | | ICD-9 CODE |
|---|---|---|---|---|
| DRUG NAME & STRENGTH | SIG | QTY | DAYS SUPPLY | REFILLS |
| DURATION OF THERAPY | | NEW THERAPY<br>* YES * NO | | |
| LAST EVALUATION DATE (mm/dd/yyyy) | NEXT APPOINTMENT DATE(mm/dd/yyyy) | | | |

Medical Justification for this condition- Include Laboratory, Physical exam findings, as applicable (attach additional information, if needed). *Specify <u>any associated risk factors</u> with the following indications-*

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| 1- PREVIOUS MEDICATION/TREATMENT | 3-PREVIOUS MEDICATION/TREATMENT |
|---|---|
| 2-PREVIOUS MEDICATION/TREATMENT | 4-PREVIOUS MEDICATION/TREATMENT |

## ApproRx Use Only

| COMMENTS: | APPROVED * | MODIFIED * |
|---|---|---|
| | DENIED * | DEFFERRED * |

REASON FOR REQUESTING THIS PRIOR AUTHORIZATION/ OVERRIDE:
*Plan Dollar Limit * Medical Necessary * Age/Gender Limitation * High-Dose * Quantity Limit
*Refill Too Soon: *Days/Supply/Maintenance * Dose Therapy Change * Vacation Meds * Lost Meds *Other:_____

DENIAL REASON CODES
1-No Other Formulary/Step Drug attempted 2-Inadequate/Incomplete Information 3-Criteria Not Met
4-Not a covered service/Plan Design 5-3-tier system/mandatory mail order

| DATE REQUESTED/REVIEWER | DATE COMPLETED/REVIEWER | RESTRICTIONS |
|---|---|---|
| AUTH FROM DATE | AUTH TO DATE | NOTES: |

**Clerk Use**: *Physician * Pharmacy * PBM * DATABASE * FILED

**Pharmacy Services- Phone: (866)-900-3711 Prior Authorization- Fax: 513-897-1022**